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THE MISSISSIPPI DOCTOR

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Here is a likeness of Dr. W. C. Walker of Houlka. He was born in a suburb of Houlka, Houston, June 14, 1859, was graduated from Vanderbilt University in 1881, and has practiced in the Houlka vicinity ever since except two years at Webb, in the Delta. He married a Houston girl in 1883; of the union six boys and two girls were born. Four of the boys are druggists, one a practising physician. Two days before the meeting of the society Dr. Walker had a birthday and he was seventy two years young. Just fifty years, one half-century, he has been in the harness. He has been and he is the beloved family physician. His spirit permeates the little town of Houlka and the territory round about, it is an inspiration to our society, and it has its power in our state society. Dr. Walker is well versed as a general practitioner of medicine. He is informed on the fundamentals of modern medicine. But he is more than a mere practitioner. He drinks deep from the fountain of human philosophy. He knows how to relate human ills and human distress, and joy, and sin and hilarity and regret. He is a corner stone in church and fraternal life in his community and his state. He bubbles over with optimism and rejoices with those who rejoice. He lends his kindly and sympathetic heart to any in need and steadies them up to higher ground. He is a student of history well versed in the lives of the leading personalities of the state. He is an orator in reality of outstanding ability. He is a physician, he is a citizen, he is a benefactor of man. It is not all of life to live and it is not all of practice to dispense pills. The practitioner of today must study the human organism in all his relations as well as the offending germ, and the extract of human kindness must be dispensed with every power of physic. May we stop and look and listen to the lesson taught by our beloved Dr. Walker. Walker Day was a great day in the life of our society.

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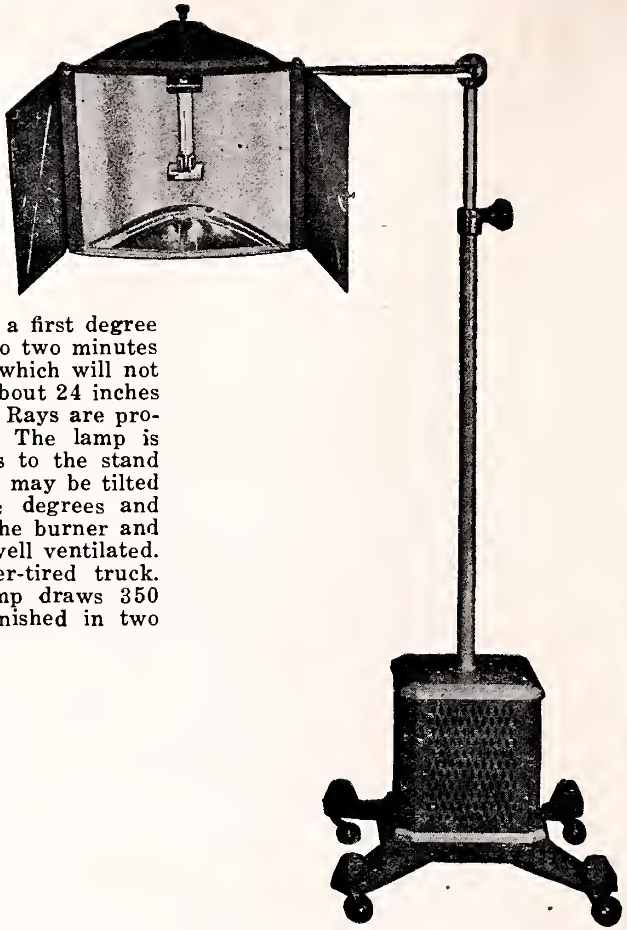

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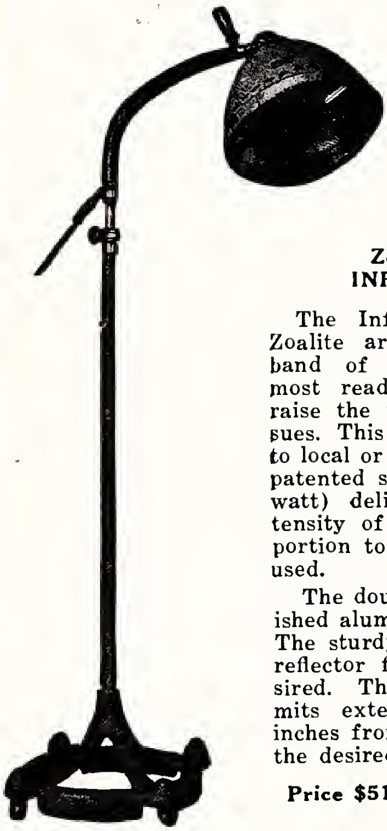

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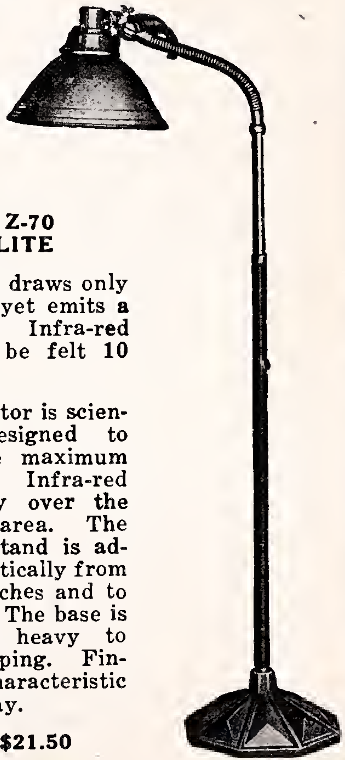

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THE MISSISSIPPI DOCTOR

OFFICIAL ORGAN OF THE NORTHEAST MISSISSIPPI 13-COUNTY MEDICAL SOCIETY
—AND—
NORTH MISSISSIPPI 6-COUNTY MEDICAL SOCIETY

W. H. ANDERSON, M. D., Editor and Manager

Entered as second-class matter, January 18, 1926, at the post-office at Booneville, Miss., under the Act of March 3, 1879.

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The Central Medical Association is publishing some health lectures on important subjects through the lay press in terms that may be understood by the lay reader. We believe this is a move in the right direction. It was thought for a long time that it was a sin for a woman to speak in public, in a mixed audience. The medical profession seems to have thought that it was a sin for it to tell anything it knew to the public. It has left this to the quacks and false scientists. There was some reason for this attitude. The medical profession wanted to be sure. But there is much knowledge that has been tested now and we should furnish this information to the public, some general information by way of the lay press and the more detailed and important by instruction in our offices. The public must realize that this service and this knowledge can not all be had without cost. Good health is our greatest asset. It is the best investment for the public.

The hospital committee appointed by the State Medical Association at its annual session in May, met in Jackson on July 7th. The chief aim of this committee is to secure state funds for charity patients throughout the state. If the small hospitals come up to a standard of safety under the plan being advocated by the state association they will receive a proportionate part of the state funds. This is as it should be. This will bring medical service to the people or help to. It will raise the standard of efficiency of the medical profession. It will be a great economical saving to the people. It will enable the public to have better medical service at less cost. This committee will see that each candidate for governor, lieutenant governor and representative has a chance to express their ideas on this subject. Let every member of the profession make this a personal matter and see to it that your lawmaking candidates are informed on this subject. It is a great move forward. It will help to keep us out of state medicine. It will help to enable the physician to have medical education brought to him as well as to his clinetele. Let every one get waked up and be about his professional business.

The association of Southern Railway Surgeons had a successful session in Washington, D. C. June 23, 24, 25. Dr. Dunbar Newell was president. He is one of the outstanding and one of the guiding spirits in this association. When you speak of Chattanooga you at once think of the Newells. He delivered an able address. He urged that the Southern Railway System furnish a two weeks intensive course of study each year free to its members to increase their efficiency. He pointed out that this would be good business for the rail roads as well as the physicians. This idea met with a very hearty response. We predict that this idea of Dr. Newell's will become a reality.

We extend a cordial welcome to the druggists of this territory. We are glad to have you come to our town. Your calling is a noble one and its importance is being realized more and more each day. The pharmacist is an important branch member, or should be, of the medical profession. One of the greatest powers behind the throne to many a successful practitioner is his pharmacist behind the counter. He is a safeguard to your clientele also. The busy physician nowadays has no time to dispense his own drugs, the pharmacist has no time to practice medicine. The pharmacist enables you to get better service from your physician without additional cost. His work is one of detail, and accuracy should be his watchword. The physician, the pharmacist, the dentist and the nurse make up the medical profession. There should and there must be a closer co-operation between them and a better understanding, especially between the physician and the pharmacist. Each and every member of these professions should sit in council in the administration of every hospital. They should meet together and discuss their problems. By so doing they can better serve a common clientele. And another advantage, they can weed out the dead beat much more efficiently, they can share the small funds that many may have, and one will not get it all and leave the patient poor and without relief. The druggist, the pharmacist, is coming to his own and he will enable the medical profession to do much better work. His importance has not yet been fully appreciated by the public, nor by many in the medical profession. May due honor be accorded him and may his importance be fully realized, may his vision of service continue to grow and widen. His opportunities for services are great. We congratulate the druggists on their progressiveness in having their meetings. We welcome them to our town and we wish them much success.—Independent, June 5th.

The Southern Medical Association will hold its next session in New Orleans in November. Dr. Felix J. Underwood, one of our members and Mississippi's distinguished Secretary of Health, is president. Mississippi should turn out in full. We should do honor to our president. We shall be well repaid by the splendid scientific program, and we shall have a visit to an interesting city and to the finest undergraduate medical school in the United States.

Dr. Edward Henry Cary, of Dallas, Texas, was elected president of the American Medical Association at its last meeting which was held in Philadelphia. This association bestowed worthily and well the highest gift within its power in thusly honoring Dr. Cary. The south is proud of him, the American Medical Association is honored with him as its banner bearer. He has the professional mind, the medical soul, and the missionary heart. He is outstanding in his specialty and he has done much work for organized medicine. We were honored to have him on our state program at Jackson in May. "The Mississippi Doctor" expresses joy and offers congratulations to Dr. Cary and predicts much progress in the association under his leadership.

The hospital committee appointed by the State Medical Association, as provided by the resolution adopted at our Starkville meeting in March, held a meeting in Jackson a few days ago. It was a very harmonious, business-like and determined committee. It is now squarely on the job. A systematic plan is being put forth to inform the public and to see that all candidates for governor, lieutenant governor, and legislative bodies understand what we want. You are now familiar with this move. Do your part to make it a success. United effort will count.

Our June meeting at Houlka was a great success. Dr. W. C. Walker in a kind of joking way has been inviting the society to meet with him for several years, and every one seemed to think it was a big joke, Houlka being so small. But the joke is on the society now and Houlka is the biggest town within our society borders if it is to be judged by its ability to entertain. The Houlka meeting was a real epoch in the life of our society. There was a fine turnout of our own members and there were many visitors. There were no trains switching to jar the quiet, no smoke to stifle, and the nice shower had obliterated the dust. The meeting was held in the modest Methodist Church on a slight elevation by the side of the road-street. On the inside it was comfort itself. The ventilation was perfect, the windows were shaded and stained, the big ceiling fans whirled quietly, the acoustics fine, and the atmosphere charged with divinely peaceful and earthly cordial, sincere, welcome, and brotherly love. The North Mississippi Six Counties Society met with us and this added delight. Many visitors from other parts of the state and from Memphis were present. Dr. Percy Toombs, of Memphis, was an out-of-state essayist who was greatly appreciated. Dr. J. C. Culley of Oxford, President of the State Medical Association, was present and Dr. Mull, Dean of the Medical Department of Ole Miss. Felix J. Underwood, president of the Southern Medical Association, one of our most distinguished members was with us. The scientific program was unusually good, and it was presented well and received very graciously. Dr. J. C. Culley spoke of some of our medical problems. He discussed two of great importance to us this year. He came out strong for the proper distribution of charity funds to the small hospitals throughout the state and he made a plea for the Medical Profession of the state to rally around the banner of our medical department at Ole Miss. Dr. Mull spoke most interestingly of our medical school and touchingly of the strong friendships he had formed while in Mississippi. Dr. Underwood expressed appreciation of the compliment paid him by the increase in membership of the Southern Medical Association in Mississippi since he had been elected to this signal honor. He urged the membership to attend the meeting in New Orleans this fall. Songs with music by the local lasses added to the sublimnity of the occasion. Their voices were quite good and there was a ring of sincerity and welcome and gratitude that was touching.

After the program at the church was ended, the large crowd made its way to the beautiful grove hard by the residence of the veteran practitioner in whose honor the associations were holding this session. The grove was very inviting. The tables were long and strongly built, the town and country folk were there in multiplied numbers, and of all the bounteous baskets we have never seen before on such order. The tables groaned, swayed and staggered under the load of heaped up plates. There was chicken, nice and tender, chicken fried and chicken stewed, baked and broiled, and beef appetizing, and country ham smoked with hickory wood that would stimulate the salivary glands of a stone man. And then there were the pickles and pies and cakes and multiplied accessories, by jinks. All in all such a bounteous repast we have not witnessed before. The food was not only bounteous, appetizing and plenteous, but the clever folk who served and the spirit of good fellowship that charged the atmosphere multiplied the pleasures and activated the digestion. For this wonderful picnic we are told that Dr. Walker's daughter was due a large part of the credit. We must not forget that Dr. Hood had a big part in all the entertainment. He is following right in the Walker footsteps.

But the meeting was a Walker Day. It was good to be there. It was refreshing. Every one who attended should take heart and courage. We should catch the vision, we should cultivate within us the Walker spirit. The truly great do not live in vain. Unselfish service will not return unto us void. Unselfish service can not be destroyed. The appreciation and the gratitude of that little town for Dr. Walker is truly inspiring. May the Walker spirit leaven our society and other societies. Our hats are off to Dr. Walker, to Miss Walker, to Dr. Hood and to Houlka. Let us go forward with the Walker spirit, with the Houlka, and let us not grow weary in service.

And again some day we hope, the cry may be, "On to Houlka."

Congratulations

June 16, 1931

To Northeast Miss. 13 County Medical Society
Houlka, Miss.

Conjointly with the other members of our Clinic we wish to congratulate the society upon the nice compliment paid Dr. W. C. Walker in having held this memorable meeting in Houlka to do him honor. We all know and love Dr. Walker and in showering an honor upon his head while he is still active. The compliment indeed reflects itself upon the beautiful sentiment of the members of this splendid society.

J. A. CRISLER

Copy of telegram sent to meeting at Houlka.

Dr. Walker

As the sun rises from the east
Bringing light to man and beast,
With all the trees and grass so green
Such as I have never seen.

My thoughts run back to days of yore
Bright and happy days to be no more,
But still I had my sorrows too
As all of God's dear children do.

A name flashes vividly in my mind
A wortheier name I can never find,
Than Dr. Walker, true and intrepid
Who is forever helping some invalid.

He administered my great grandmother
My great grandfather and his brother
And all the rest down the line
Until now, this lapse of time.

He was at home when sister died,
There with us close, by her side
Trying all his medicines and arts
As a balm for our aching hearts.

Mother used to call him when I was ill
Probably when I had some terrible chill
I always knew by his knock at the door
That I would be well in a few days more.

From Calhoun to Monroe, Pontotoc to Clay
He rode Bell, Bob, Billy, and Lady Gay
Administering the feeble, helping the poor
Cheering them up with his balmy cure.

He used to ride a fast dapple gray
As he went on his calls every day
I knew him as a low and slender man
Always with a satchel in his hand.

His plump eager horse's name was Dot
Who always journeyed in a swaying trot.
She was always prancing and never still
Wanting to climb every valley and hill.

He and Dot both used to intinerate
From house to house, gate to gate,
Healing the sick, getting them well
Relieving more pain than tongue can tell.

He has been a national Savior to us
Rendering more service than I can discuss
Always living in Houlka Grand,
Lending a strong and uplifting hand.

I owe my life to that very man
Who has helped me to run my span,
His smiling face proves he has won
Signifying his work is well done.

The silver-tongued orator of the Medical pro-

fession
A friend to all and Mississippi's appreciation,
Jolly and full of fun and mirth
And a man of meriting worth.

Don't be a monkey on a string,
But stop and let your praises ring
Kindly express your thanks sincere
For his kindness and let him hear.

When stars are counted for his crown,
I'm sure he'll get an extra for renown,
One that will out-shine all the rest
One that will love and treasure best.

(Through love and gratitude to Dr. W. C. Walker from Helen Mathes, Houlka, Miss.)

From Here and There

The meeting of the committee on Hospital Legislation had a meeting in Jackson July 14, all the members being present except two.

Dr. R. H. Christian, graduate of Vanderbilt University and interne from Shreveport Charity Hospital, has opened his office in Baldwyn, where he takes up a large part of the practice left by the death of Dr. J. C. Vandiver. Dr. Christian's home-town is Smithville, and he comes to Baldwyn with the good wishes of many friends in the profession.

Many are interested to know that Dr. W. C. Walker, of Houlka, is recovering nicely from a few minor injuries incurred in an automobile wreck near Houlka July 3.

Dr. O. F. Carr has the sincere sympathy of his many friends in the loss of his mother, Mrs. O. C. Carr, who died at the ripe old age of 81 on June 26th.

A Pontotoc County Vital Statistics Association was organized here June the 30th on the occasion of the visit of Dr. R. N. Whitfield of the State Board of Health.

Dr. O. F. Carr and wife, of Pontotoc, are visiting their daughter, Mrs. William May Jr., of Lombardy, Miss this week.

STAFF MEETING—HOUSTON HOSPITAL
HOUSTON, MISS., July 2, 1931

Subject: "Bronchography," led by Dr. J. R. Williams and discussed by all present.

These meetings are always well attended by doctors from several adjoining counties. They meet twice a month.

Differential Diagnosis Of Heart Murmurs In Children

R. E. PRIEST, M.D.
Houston, Miss.

In this twentieth century when medicine has been divided into various specialities and practically re-written, when volumes and volumes of literature are pouring out from the medical press each day, is it any wonder that the modern physician cries aloud in his medical wilderness of old and new books, and staggering mountains of medical journals for someone to condense and simplify the essentials in various subjects, so that "he who runs may read."

The author of this paper claims nothing original in its presentation. It is simply a symposium or the A. B. C's of the basic points in differentiating some of the most common murmurs of heart diseases of children. Stanley Nichols states that thousands of children in this country are condemned to lives of partial or complete invalidism because of a functional heart murmur being mistaken for an organic one; or a child with acquired heart disease being needlessly restricted, when his heart lesion is in a quiescent state, and no heart failure present. The salvage of these children, with their depressed mental outlook, and their conversion into happy, useful, and active children, represents one of the most important things that confronts the pediatrician and the cardiologist of today.

When we hear a heart murmur in a child, what should we do? Two things: (1) Adapt a negative attitude as to its being an organic lesion until we are very sure of our diagnosis. Remember that, to the public a verdict of organic heart murmur means invalidism, terror, and ultimate death. (2) Determine to what group of murmurs the one to which we are listening belongs.

What are the main groups to consider?

First: Congenital heart murmur.

Second: So-called functional murmurs or non-pathological.

Third: Acquired heart murmurs in: (a) acute septic endocarditis; (b) sub-acute bacterial endocarditis; (c) rheumatic endocarditis; (d) luetic heart disease; (e) thyro-cardia disease, (f) heart disease associated with hypertension and arterosclerosis. In view of the fact that the last three mentioned conditions are so rare in children as to warrant their exclusion.

(1) CONGENITAL HEART MURMURS

What are the important findings that would lead us to place a murmur in this group? First: Synosis. From seventy to ninety percent of congenital heart cases show this to some degree, often accompanied with club fingers.

Second: Loud and long murmurs. As a group, congenital heart murmurs are much louder than acquired of functional heart murmurs and also much longer. Many of them extend into both diastole and systole.

Third: Persistent murmurs, discovered in the first two years of life. Very few acquired heart murmurs are found in the first two years of life. Most of these are associated with septic processes; a few are rheumatic.

Fourth: Loud murmurs with maximum audibility at base of heart to the left of the sternum and along the sternum down to the ziphoid cartilage, and most of these are accompanied by a distinct thrill. A bulging chest deformity in the precardial region with a marked delay in growth, accompanying the preceding symptoms.

After placing a murmur in the congenital group, what is the importance of further differential diagnosis of the various murmurs? From the practical standpoint—very little. The greater the cynosis, the poorer the prognosis as to the probable length of life. Little can be done for these cases except to avoid over-strain and to prevent infection. From a scientific standpoint an accurate and complete differential diagnosis is very difficult as the great majority of congenital lesions are multiple defects.

While complete study of all these lesions is not possible within the limits of this paper, we might mention the most common ones which fall into three groups. First, the pulmonicstenosis, the most common of all congenital lesions. This is a loud, rough systolic murmur heard best in the second left interspace near the sternum, plus a systolic thrill felt best at the same area. Second: Septal lesion—prolonged, systolic, often heard loudest over the sternum, particularly the lower two thirds. Third: patients ductus artiosus—prolonged humming top murmur, usually heard with both systole and ddiastole. The older the child, the less likelyhood of the murmur being a congenital one as less than ten per cent of children with congenital murmurs live to the age of fifteen years.

(2) FUNCTIONAL HEART MURMURS

Functional heart murmurs are non-pathological heart murmurs, the anatomical cause of which is not known. What are the suggestive points that would lead us to put a murmur in this group? First: Diagnosis by exclusion of congenital and acquired heart murmurs. Any murmur that cannot positively be placed in the acquired or the congenital group, should be put, at least temporarily, in this class. This is a proper practice, as it is commonly accepted that there are more non-pathological murmurs than there are congenital and acquired.

Second: These murmurs are soft and short.

Third: Murmurs which may be inconsistent and variable.

Fourth: Systolic, heard most commonly in the pulmonary area (area of romance).

Five: Accidental murmur.

The simplest way to classify the functional murmurs individually is to place each in one of the following groups, depending on what we believe to be the underlying cause of the murmur: (a) Cardio pulmonary, (b) hemic murmurs; (c) atonic murmurs in asthenia and fever; (d) venal hums (murmurs at the base); when we place a heart murmur in this non-pathologic group, we should listen to this heart at least once a month for a year, but allow no restriction on the child's activeness during this period. This will suffice to prove or disprove the accuracy of the first diagnosis, and also serve to keep the case out of the hands of some misguided murmur enthusiast, who would immediately on hearing the murmur give the child digitalis which might invalidize the child. Allow me to digress long enough, while I am on the subject of digitalis to say that it has no place in the management of heart conditions in children, except when there is a fibulation, which is very rare in children, or in the case of heart failure.

(3) ACQUIRED HEART MURMURS

Acquired heart murmurs may be diagnosed by a rheumatic history.

First: Evidence of some phase of rheumatic fever, chorea, repeated attacks of fobicular tonsilitis, rheumatic nodules, so-called growing pains, and the typical rheumatic skin lesions which are found in the majority of acquired heart murmurs.

Second: Cardiac enlargement which is present in most cases.

Third: Murmurs with definite characteristics. There is nothing characteristic of a murmur to help us place it in the bacterial endocarditis group. This is done only by blood culture in cases with suspicious symptoms when we find persistent hemlatic streptococci in the blood, associated with a rapid septic course of fever, severe and often purulent arthritis and emboli, it usually means acute bacterial endocarditis.

(4) TRICUSPED INSUFFICIENCY

This condition never exists alone, being a systolic blow, heard over or near the lower sternum, associated with a pulsating liver, usually present with other murmurs as a relative one, being part of a general cardiac dilatation.

The most common and important acquired heart murmurs are those of the mitral and aortic disease. Some of the essential points in diagnosing the four most common heart murmurs selected from a group compiled by the New York heart association are here presented:

(5) MITRAL INSUFFICIENCY

The diagnosis of mitral insufficiency can be made in the presence of cardiac enlargement, associated valve disease, or a rheumatic infection history, and the presence of a typical murmur. The murmur is systolic in time and may accompany, follow, or replace the first heart sound. To be typical, it must be relatively high in pitch and prolonged.

(6) MITRAL STENOSIS

The diagnosis can be made by the presence of a typical murmur, prolonged, low in pitch, and of a rumbling quality, beginning immediately after the second heart sound. It is systolic in time and is best heard with the child lying on its back after a considerable amount of exercise.

(7) ACTIC INSUFFICIENCY

The diagnosis of which can be made by the presence of a typical murmur. Its quality is blowing; its pitch is high. The murmur resembles the respiratory murmur and should be listened to with the child holding its breath. The time is diastolic. It is best heard at the third and fourth interspaces at the left border of the sternum, and in the second and third interspaces in the right border of the sternum.

(8) ACTIC STENOSIS

The diagnosis of actic stenosis can be made from a systolic thrill heard best from the second interspace near the right border of the sternum, or episternal motch accompanied by a rough systolic murmur loudest at this place. The diagnosis of actic stenosis should not be made unless aortic insufficiency is already proved.

PROGNOSIS

The importance of the differential diagnosis of these last four murmurs lies in the prognostic value of such findings. Mitral insufficiency, which after a lapse of time shows a tendency to progress into a double mitral lesion, which is typical of a progressive rhemuatic form of heart disease, and is one that usually gives us the most trouble. Aortic insufficiency is much less common, while quite as serious. It tends to break down in late childhood and early adult life.

Diagnosis In Rural Practice*

L. H. HIGHTOWER, M.D.
Itta Bena, Miss.

*Presented by invitation at Belzoni meeting, Delta Medical Society, October 8, 1930.

There has been no effort to make this a scientific paper. That it contains nothing new will be apparent. That it has any value is doubtful inasmuch as its value must come from an imperfect recital or repetition of facts, usages and procedures familiar to all well-informed practitioners such as make up the membership of this Society.

As it is often helpful and refreshing to sing again the old songs and read anew the masterpieces of fiction and literature that we read in the long ago, so in medicine it is sometime worth our while to pause and review and rehearse some commonplace, basic truths and principles that enter into the very foundation of our profession.

The title selected for this paper was suggested by several conditions. First, a large percentage of the membership of this Society is made up of rural practitioners, that is, physicians living in small towns doing extensive rural practice. Second, the small town or rural physician is seriously handicapped in the matter of diagnosis in that he is denied the advantages of ample laboratory facilities, trained technicians, Roentgen ray equipment and other essentials to good diagnostic work.

In view of these facts and the further fact that correct diagnosis is the keystone of the successful practice of medicine and that a physician's usefulness and efficiency is measured to a great extent by his ability as a diagnostician, it is apparent that the successful country doctor must strive at all times to improve along these lines and to make the most of the diagnostic means at his command.

Diagnosis implies a thorough knowledge of the patient as a whole and a clear conception of every particular in which he deviates from the normal, healthy individual. It is not enough to know that the patient has pneumonia. We should of course know whether there is a co-existing or complicating pyelitis or nephritis, a diabetic tendency or syphilitic taint. Whether there is valvular or myocardial disease, the presence or abscence of gall bladder and all other focal infections should be noted. The same rule applies to all other diseases acute and chronic.

The patient may be satisfied with the simple diagnosis of malaria, pellagra, or syphilis but the painstaking physician will use every means at his disposal to detect every defect and every deviation from the normal, and having done so he places himself in a position not only to cope more successfully with the condition, but also to retain the confidence of his patient and explain any failure or disappointment in the treatment.

It is true that the diagnosis of the majority of the cases of acute illness met with in our Delta practice does not present a specially different problem, but there is encountered in our rural practice a great number of chronic, irregular, unclassified cases with indefinite symptoms and imperfect histories, combined frequently with vicious habits, bad living conditions and ignorant and superstitious prejudices. These cases represent an economic loss as long as their disability continues. Their means will not permit their going to high class clinics, the greater part of them must be taken care of by the country doctor, who with the history, symptoms, physical findings and the laboratory tests at his command, must make the diagnosis, administer appropriate treatment, or have the patient pass on to his competitor.

As stated, the first step in making a diagnosis is usually to secure the history of the case which includes family and personal history and history of previous and present illnesses. History taking, to be useful, requires tact, skill, patience and a sympathetic interest in the patient's case. Nothing is more encouraging to a patient or more helpful in bringing out all the facts than for him to feel that the physician sincerely desires to relieve him. Every fact in the family and personal history as well as in the history of previous illnesses that could possibly have any bearing on the case should be brought out. The importance of complete, accurate, systematic collection of all essential history data can not be overestimated. History of the present illness is even more important and should be accurately brought out and carefully considered.

In considering symptom it is well to remember that in a great many cases encountered in rural practice in the Delta the symptoms are frequently misleading, indefinite, atypical and sometimes positively contradictory, but it is good practice to listen attentively to those considered most important by the patient. Then by careful inquiry a flock of others can be elicited some one of which may give a correct lead in the case. Symptoms are valuable when coming from an intelligent patient but must be studied carefully at all times and a diagnosis should never be made on symptoms alone. To do so will frequently lead to error and embarassment as in the case of the doctor called at night to a young girl who had suffered a sudden attack of abdominal pain, acute localized tenderness over McBurneys point, with fever, nausea and vomiting. Without further investigation and failing to note in the dim light of the room the small appendectomy scar he expressed the opinion that she had appendicitis. To his dismay he was informed that her appendix had been removed a year or so previously. Urinalysis revealed a rather severe pyelitis which promptly responded to treatment. Of course the first attack was appendicitis as the scar indicated but the second was not. It is a safe rule never to make a diagnosis of appendicitis in females until you can definitely rule out salpingitis, ovarian disease and pyelitis.

After history and symptoms comes the physical examination. Here the country doctor who graduated two decades or more ago may not make the fine scientific distinctions of the highly trained modern internist, but with careful, persistent study of each and every case he will almost always be able to detect the deviations from normal. Routine examination will detect pyorrhea, bad tonsils and dental caries while with care abscessed teeth or an infected antrum may be diagnosed without Roentgen-ray or transillumination. The tongue will frequently give a valuable lead notably in malaria, pellagra, typhoid, scarlatina and auto toxemia. The ears should always be included in routine examination, condition of cervical glands and thyroid should be noted. The chest should always be stripped for examination. Heart is examined for size, position, murmurs, irregularities and rate. A rapid heart without discoverable cause should always excite suspicion of hyperthyroidism. The lungs are examined for impaired or increased resonance, increased or absent vocal fremitus, dullness, flatness, the various rales, friction sounds, cavernous and tubular breath sounds, edema and any other abnormal condition.

The abdomen is examined to detect tender or enlarged spleen, epigastric tenderness; tenderness or enlargement of liver; tenderness over gall bladder region, a very important point as it frequently happens that a patient may have a chronic cholecystitis which may be easily overlooked and yet may be the source of all his trouble. We also look for tenderness over appendix; over the lower pole of each kidney and over the entire course of the colon. Evidence of acute or chronic peritonitis and meoplasms should be noted.

Rectal examination reveals presence or absence of piles, fissure, fistula, neoplasms and in men the condition of the prostate.

Examination of female genital tract reveals presence or absence of uterine, ovarian or other tumors, uterine or extrauterine pregnancy, tubal disease, veneral infection, malpositions, labor injuries and malignancy.

The blood pressure should always be carefully and correctly taken and properly interpreted. The pulse pressure generally accepted as normal is 50 percent of the diastolic pressure. Increase of the pulse pressure usually indicated hypertrophy of the heart as seen in aortic regurgitation. Lowered pulse pressure usually indicates an impaired myocardium and if persistent is of serious import. A persistently high pressure of normal ratio as we all know, usually, though not always, indicates nephritis or arterio-sclerosis or both, is of grave import and should always receive careful consideration.

Laboratory tests available to the country doctory either in his office or in our State laboratory are urinalysis, Wassermann, Widal and typhoid culture, and examinations for malaria, tuberculosis, gonorrhea, diphtheria and undulant fever.

Urinalysis to include specific gravity reaction, sugar, albumen, pus and casts should be made in every case without exception. The findings are sometimes very surprising as well as very valuable. A Wassermann is desirable in all office cases and should certainly be done in all cases presenting obscure symptoms. Examination for malaria and a typhoid culture should be made as early as possible in all fever cases. A negative Widal is of no value for the first two weeks. Examinations for tuberculosis, diphtheria and gonorrhea are made in appropriate cases. The test for undulant fever should be made in all cases of irregular persistent fever for which no other cause can be found.

When all possible information has been secured through history, symptoms, physical examination and laboratory methods the diagnosis is made, sometimes correctly often times incorrectly. But if we have been careful, systematic and conscientious there will not be as many errors as one might think and when failures are recorded, we have the satisfaction of knowing that we have done our best.

In conclusion, the points we would emphasize are:

1. Eternal vigilance, combined with hard work is the price of good diagnostic work.

2. Whatever is worth doing in medicine, is worth doing well and thoroughness is the scret of success.

3. Diagnosis should never be attempted off hand. Inevitable failure will result.

4. Nothing should be taken for granted in

diagnosis.

5. The patient's complaint should never be dismissed as trivial until you can prove beyond a doubt that it really is unimportant.

6. Intensive effort along these lines will result in better service to the patient, and will increase the prestige and add materially to the income of the country doctor.

Discussion of Dr. Priest's paper "Heart Murmurs in children."

Dr. S. N. Green: I thank Dr. Priest for this very fine paper. I have no discussion to make.

Dr. Adams: I don't feel that I am competent to add more to such a well organized and well worked up paper. However, I should like to say something in regard to the differentiation between the normal and abnormal heart in the child. In order to be a good diagnostician, we should first be able to recognize the normal physical findings. As you all know, the pulse in early life is not only more frequent, but it is very much more variable, as to the rate, rhythm and intensity. When rapid, it is frequently irregular without special significance. As to the apex beat, it is, as a rule, outside the mammary line until the fourth year. From the fourth to the ninth year, it is in or near the mammary line. After the thirteenth year, under normal conditions, it is practically always within the mammary line. During the first year the apex beat is usually found in the fourth intercostal space; from the first to the seventh year, it is found with about equal frequency in the fourth and fifth spaces; after the seventh it is usually, and after the thirteenth year, it is always, in the fifth intercostal space. In infancy, the rapidity of the heart is ordinarily so great that it is difficult to determine the exact period in the cardiac cycle at which a murmur occurs. Nearly all of the abnormal murmurs heard, are systolic; especially in early childhood. Accidental murmurs are very common, and are often heard even in infancy.

Focal Infection

Z. A. DORSEY M.D.
Troy, Miss.

Focal infection is the term applied to general or local systemic disease resulting from infection or bacterial intoxication arising in some focus of infection. (Nelson's)

You are familiar as to how the infection is carried to some other part or parts of the body.

The most common sites of focal infection is in or about the teeth, in the tonsils, the nasal sinuses and the genito urinary organs.

It occurs in almost any part of the body, but I consider foci in the head the most important.

You are at liberty to discuss any phase of subject mentioned or not mentioned in this paper.

I consider the streps and the staphs the most important organisms. They are nearly always and perhaps are always present in foci of the head.

As to the pathology, we have sinus disease, middle ear infection, infected teeth, infected tonsils, arthritis and rheumatism in their various forms, chorea, neuritis, inflammation of different parts of the heart, arterio schlerosis, thyroiditis, appendicitis, cholecystitis, nephritis, pyelitis, erythema nodosum, urticaria, asthma, obscure fever, headache, insomnia, nervous irritability, pain in various parts of the body, herpes, sores, boils, carbuncles, debility, mental depression, dementia etc. almost ad infinitum.

I will discuss some of the ills arising from focal infection.

Sinus Infection—We older physicians can recall the severe attacks of facial and supra orbital neuralgias that some of our patients would have at times. These attacks were common in those days.

Some of them suffered for days, some would have recurrent attacks; subject to them we would say.

We shot them with morphine, filled them full of quinine, iron, arsenic and other recommended remedies and let nature heal them to our credit.

We know now that the majority of these cases were due to sinus infection.

We had no trouble with the cases caused from infected teeth because we yanked them out going and coming those days.

Irritation of the labyrinth—I will give the history of three cases to show the happy results obtained by riddance of the foci of infection.

Case 1. Male, white, married, age 35. Had severe attacks of vertigo. A thorough examination revealed nothing abnormal except infected tonsils. Tonsils were removed and there has been no return of the trouble five years hence.

Case 2. Female, white married, age 30, in the sixth month of pregnancy. Had attacks of vertigo that confined her to bed part of the time every day and sometimes all day.

A thorough examination revealed nothing abnormal except some pus cells in urine.

Medical treatment did no good.

I advised having the kidney or kidneys drained.

Cystoscopy revealed a pyelitis of left kidney which was drained and the patient had no further trouble, went to full term, had a normal labor and is in fine health eleven months hence.

Case 3. Male, white, age 3. Had attacks of vertigo that would make him frantic.

Diagnosis—Disease of the labyrinth. Medical treatment did no good. A circumcision was done as he had a phimosis and I thought it might be producing a nervous irritation.

The circumcision revealed a small focus of pus under the prepuce. The patient recovered almost immediately and had no further trouble. This was in my early career as a practitioner and I did not realize at that time that absorption from this focus of infection was irritating the labyrinth and causing the vertigo.

One of the worst cases of thyroiditis I have ever seen was due to infected teeth. Extraction of the teeth with two months rest in bed has resulted in what seems to be a cure.

Erythema Nodosum—The majority of cases of this disorder that I have had were females, white, in their fifties. They had badly infected teeth. Treatment seemed to do no good. They had to wear it out.

I am confident now that those cases were due to infected teeth.

The last case of this once troublesome disorder that I have had was a girl about twenty years of age. A tonsillectomy resulted in a quick cessation of the trouble.

Protein is absorbed from a focus of infection and sometimes produces urticaria and asthma when the person is sensitive to proteids.

A person that has a focus of infection seems to be subject to sores. We do know that sores are slow to heal when the patient has a focus of infection especially if it is in or about the teeth.

As to the genital organs the most common seats of infection are in the male, the mucous glands of the uretha, epididymis, the seminal vesicles and the prostate.

In the female, the bartholinian glands, the cervix, the corporeal endometrium, the venous sinuses and the fallopian tubes.

In stomach and duodenal ulcers have all foci of infection, in or about the teeth, removed.

Focal infection is very dangerous to the vascular system and the kidneys.

Infected Teeth—Some people seem to have a disgust for false teeth. Of course we should teach them, as we are doing, as to how to care for their natural teeth but when they can no longer have healthy teeth impress it upon them the necessity of substituting false ones.

Inform them that false teeth are always commendable when it is necessary to have them and that infected teeth are nauseating to an intelligent people and a menace to the health of the public.

We as a profession should inform the people in regard to the gravity of focal infection. People can not be centenarians, except in rare instances, until we include focal infection, especially of the head, in our health campaigns.

One of the sad pictures of life, and one we see almost every year, is a person that has been intelligent, benevolent, a great power in the uplift of his community and in his declining years becomes demented and is robbed of the joy of a happy reflection consequent on a well spent life on account of focal infection, usually the teeth.

If you desire to live to a ripe old age, free from dotage, your eyes not dimmed nor your footsteps faltered at the age of one hundred, keep rid of focal infection, especially of the head.

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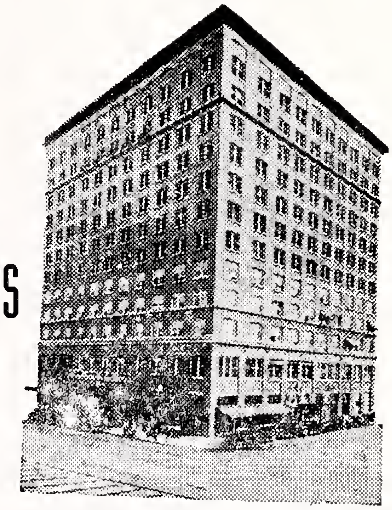

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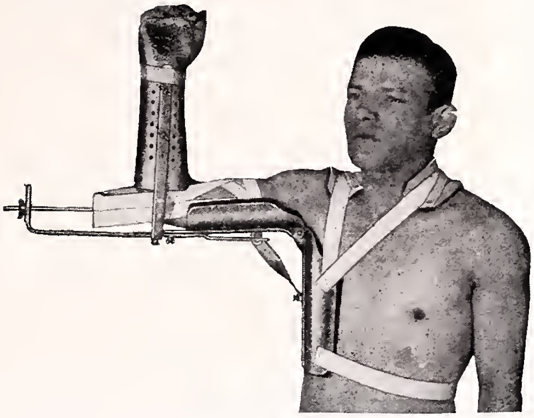

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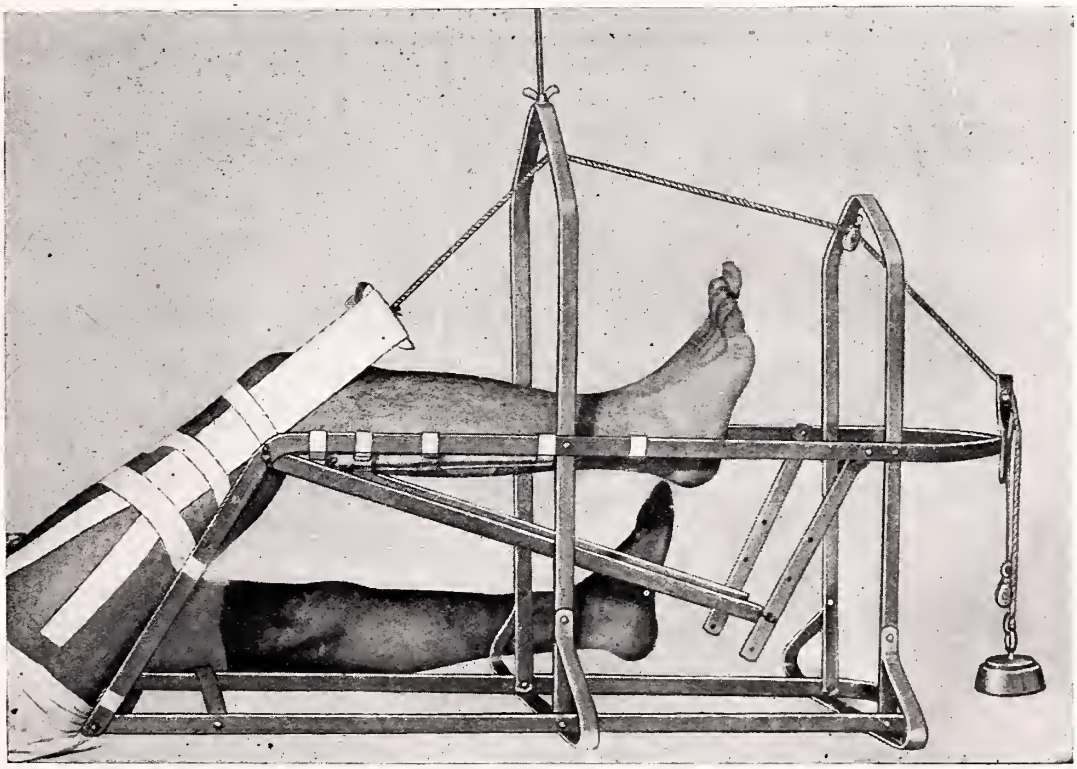

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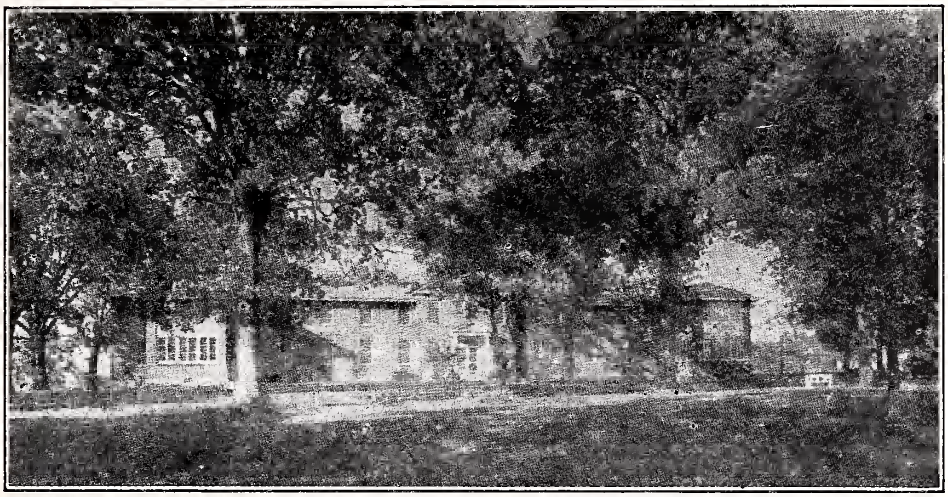

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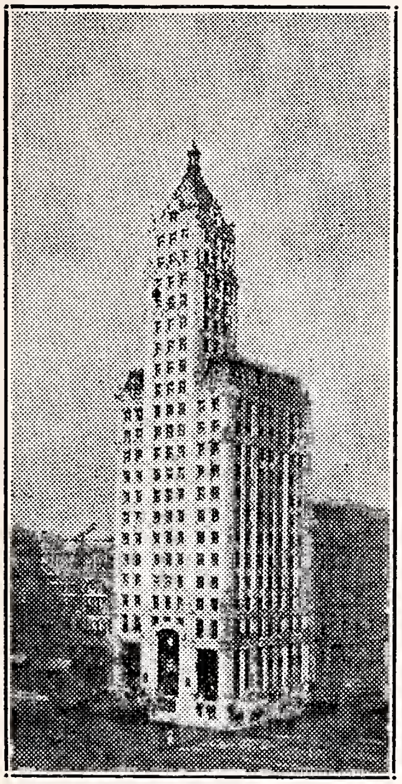

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True worth is in being, not seeming—
In doing, each day that goes by,
Some little good—not in dreaming
Of great things to do by and by.
For whatever men say in their blindness,
And spite of the fancies of youth,
There's nothing so kingly as kindness,
And nothing so royal as truth.

We get back our mete as we measure—
We cannot do wrong and feel right,
Nor can we give pain and gain pleasure,
For justice avenges each slight.
The air for the wing of the sparrow,
The bush for the robin and wren,
But always the path that is narrow
And straight, for the children of men.

'Tis not in the pages of story
The heart of its ills to beguile,
Though he who makes courtship to glory
Gives all that he hath for her smile.
For when from her heights he has won her,
Alas! it is only to prove
That nothing's so sacred as honor,
And nothing so loyal as love.

We cannot make bargains for blisses,
Nor catch them like fishes in nets;
And sometimes the thing our life misses
Helps more than the thing which it gets.
For good lieth not in pursuing,
Nor gaining of great nor of small,
But just in the doing, and doing
As we would be done by, is all.

Through envy, through malice, through hating,
Against the world, early or late,
No jot of our courage abating—
Our part is to work and to wait.
And slight is the sting of his trouble
Whose winnings are less than his worth;
For he who is honest is noble,
Whatever his fortunes or birth.

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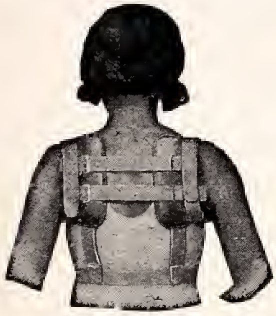

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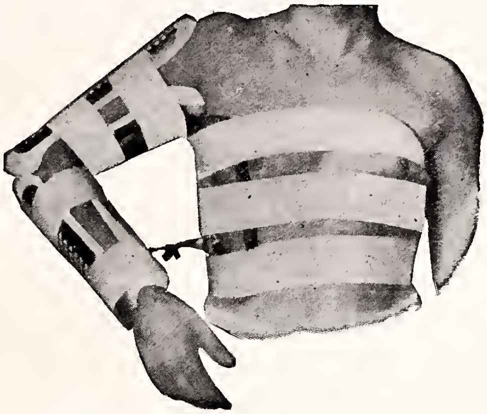

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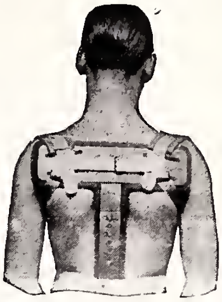

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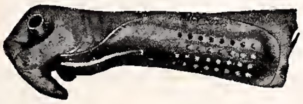

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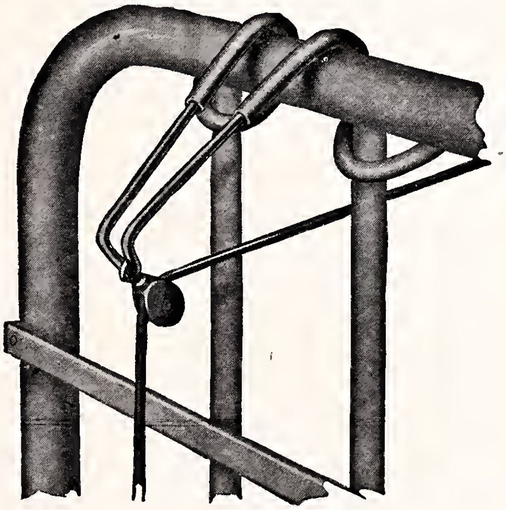

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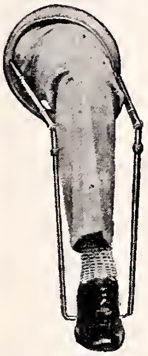

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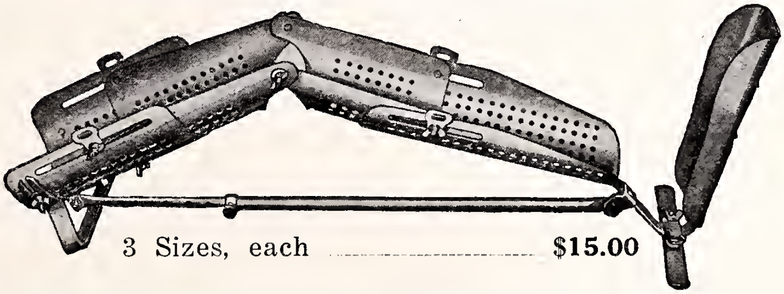

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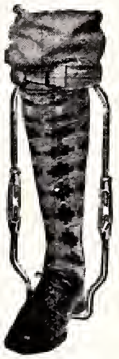

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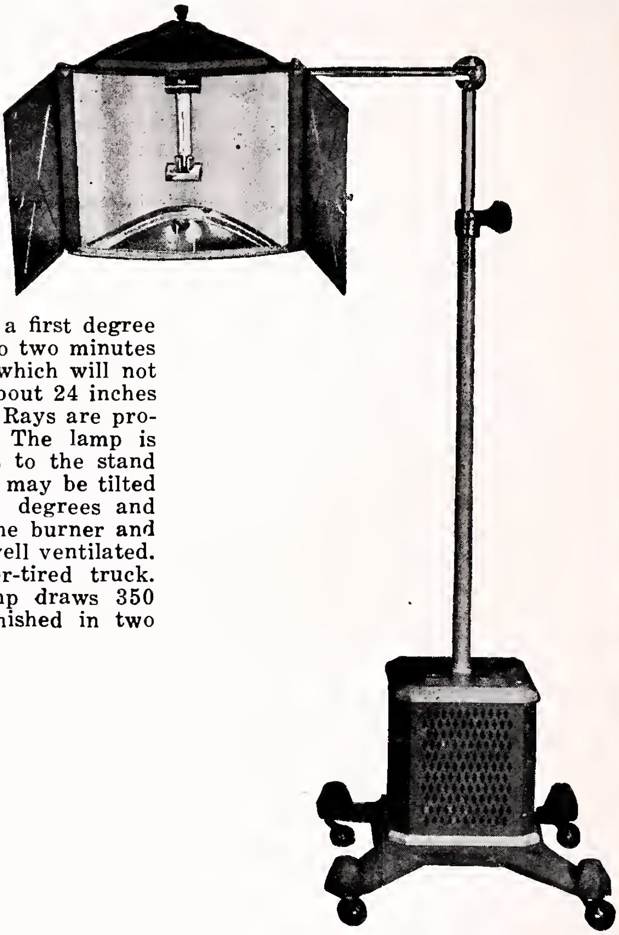

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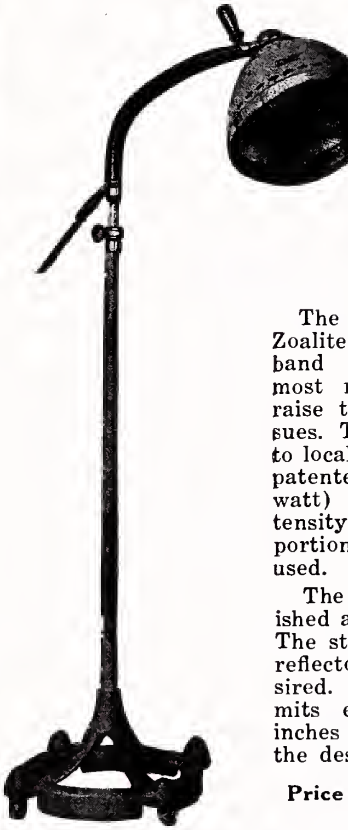

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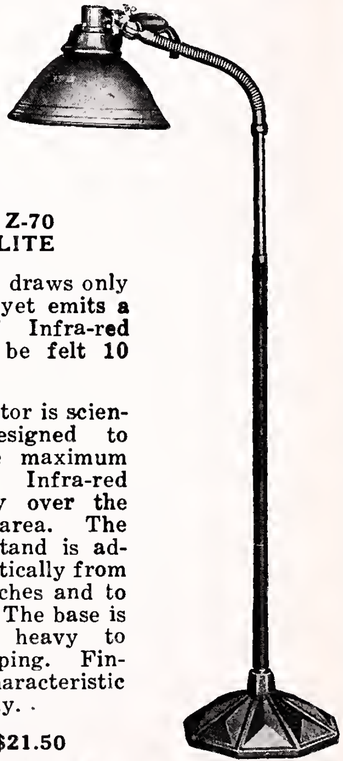

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THE MISSISSIPPI DOCTOR

OFFICIAL ORGAN OF THE NORTHEAST MISSISSIPPI 13-COUNTY MEDICAL SOCIETY
—AND—
NORTH MISSISSIPPI 6-COUNTY MEDICAL SOCIETY

W. H. ANDERSON, M. D., Editor and Manager

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You will read with interest and great profit the splendid paper of Dr. Carl Sanders, read before a staff meeting at Houston on July 23rd. It is able in content on a very important subject and it is well expressed. It is a paper in which every practitioner, every surgeon and every specialist should be greatly interested. We are delighted to have this paper for publication We congratulate the staff of the Houston Hospital on having such splendid papers read at its meeting.

We are combining the August and the September issues in one. Several of our essayists in June failed us, failed to get their papers in written form. We did not know that we would not have them in time to secure other papers. But we are back regularly on the job now and we will get to press earlier in the month and expect to publish many extra copies.

We want to ask the vice presidents of each county to assist us in securing news items. It will not take you long, it will help the journal a great deal. It is your journal, lend us a helping pen.

You may look forward with exceeding great pleasure to the get together meeting of the medical societies of the northern half of the state at Ole Miss on October the 29th. Dr. J. C. Culley, President of the State Medical Association is especially interested in two important undertakings, one the medical department at Ole Miss, the other distributing aid for the unfortunate poor by way of the small hospitals. This meeting is to do honor to Dr. Culley by enlisting interest in the medical department at Ole Miss. If the medical profession gets acquainted with this school and understands its value, then it will be kept and will serve nobly as it has in the past we believe. For the first two years in medicine, we do not believe that you can find a school in the United States that is more thorough. The young men of Mississippi have been fortunate in having this school, having this thorough training at such a reasonable cost. We want to make this a great get together meeting. We want you to turn your eyes to Ole Miss next month for one day. We expect to have a program that will interest you. The deans of Tulane, Vanderbilt and the University of Tennessee Medical Schools are expected to be there. Governor Elect Mike Conner will be on the program. Other prominent men will be with us. The meeting will be called at ten in the morning and will last throughout the day. Set this day apart, go over to Ole Miss and get acquainted with the medical department in this splendid school. This school, this two years in medicine, must not go. The medical profession of Mississippi can save it and make it bigger and better. Look for the full program in the October issue of the Mississippi Doctor.

The passing of John Osborn Polak, of Brooklyn, on June 29th brings sadness and regret to the entire medical fraternity of this and other nations and to the hearts of thousands of patients who loved and admired him. Dr. Polak was exceedingly popular in the south. He was on the program of the Tri-States last February. When his name was listed on any medical program in the United States a large audience was assured. Dr. Polak mastered the details of the practice of Gynecology and Obstetrics. He was an able teacher, an outstanding writer, and a magnetic and forceful speaker. He not only gave detailed attention to his patients and to his students, but he gave much study to the relation of modern medicine to the social and economic life of the nation. You will recall the able editorial on the front page of the Mississippi Doctor in the March Issue written by Dr. Polak. Although he was born and reared and practiced for forty years in the city, he saw the solution to the cost of medical care in the development of the "community hospital". John Osborn Polak had a profession mind, a medical soul and a missionary heart. We are much poorer because of his going, but infinitely richer at his having lived, richer in the details of medical truths and richer in the vision that he gave us of the great opportunities of service we have in the medical profession. He was the outstanding master and artist in the application of modern medicine and surgery, as well as a constructive leader in new ideas in this profession. His magnetic personality touched and inspired all with whom he came in contact.

We regret very much the untimely death of Dr. Gill, of Newton. His health had not been so good for some time. He was well known in the profession of this state. He was very active in all of its undertakings. He will be greatly missed at our state meetings.

The passing of Dr. W. W. Smithson took from the stage of action in Mississippi one of the outstanding personalities of the profession of this state. He had been a leader and had been highly honored by the profession. He was a leader in medical thought. He was an able practitioner. He was a citizen who took an active interest in every move for the betterment of his state. He was a most magnetic personality.

FROM HERE AND THERE

Dr. J. R. Hill was elected as representative over many opponents with a good majority. The district could not have chosen a better representative.

Dr. Carl W. Norwood spent the month of June doing post-graduate work at the Mayo Clinic, Rochester, Minn. He was accompanied by his family.

Dr. Claude F. Gilbert is spending the month of August at the Mayo Clinic in post-graduate studies.

Mississippi doctors who died recently were:
Dr. James B. Britt, Blue Mountain, July 28.
Dr. L. L. Greer, McComb, July 11.
Dr. Wm. Tillman Duke, Glen Allen, July 22.
Dr. Frances V. McRae, Brookhaven, July 17.
Dr. W. R. Eatherly, Winterville, July 7.
Dr. I. T. Woodruff, Batesville, July 11.
Dr. Wm. Thomas Hunter, Decatur, June 2.
Dr. W. W. Smithson, Jackson, Sept. 9.
Dr. W. G. Gill, Newton, August.

Chronic Myocardial Disease

By L. CARL SANDERS, M.D.,
The Polyclinic
Memphis, Tenn.

Chronic myocardial disease is that form of heart failure in which the valves and pericardium are normal in appearance. In a large percentage of cases the heart shows no demonstrable lesion or abnormality other than hypertrophy; in a small percentage fibrous myocarditis is found.

The number of myocardial cases has increased since the influenza epidemics of 1918 and 1921; the toxins of influenza seem to definitely impair the muscle tone. This is particularly true if patients resume activities before convalescence is complete. The severity of the infection apparently bears no relation to the amount of damage to the heart muscle.

Signs of cardiac failure which develop after the age of forty strongly suggest myocardial rather than valvular disease, especially if no history of rheumatic fever is given. After the age of fifty this probability is much increased.

Etiology—Not a great deal is known about the cause of this type of heart disease. Autopsies on patients who have succumbed on account of myocardial failure have revealed that the heart valves may be normal, the muscles unchanged, and the coronary arteries unobstructed. Certain groups of myocardial cases, however, are associated with definite pathological changes previously existent.

In the light of recent studies, the various chronic and acute infectious diseases, rheumatic fever, syphillis, hypertension, obesity, chronic cholecystitis, and prostatic hypertrophy with obstruction assume an important role in the production of myocardial disease.

Chronic foci of infection, particularly dental sepsis, chronic tonsillitis, and diseases of the perinasal sinuses are recognized as contributory factors to the weakened heart muscle.

Acute infections are also predisposing causes. The heart may become weakened through distortion and destruction of the valves, or by direct damage to the cardiac muscle. Rheumatic fever is more destructive both to the muscle and valves than any other acute infectious disease.

Syphilis effects the myocardium in all instances after the infection has reached the blood stream. The changes consist of an interstitial inflammation; the muscle fibers become fragmented and lose their nuclei, and new fibrous tissue develops to replace the destroyed cells. This process leads to the formation of scars. The muscle fibers about these scars gradually stretch, producing dilatation and decompensation. Worthin has found spirochetes in sections of heart muscle at autopsy on persons who had syphilis during life.

Chronic myocardial disease due to hypertension causes fairly characteristic changes. Both ventricles are markedly hypertrophied and dilated, and on microscopic examination proliferation of connective tissue within and between the muscles may be seen. The ventricles are affected first, but later the auricles become involved. It has recently been shown that in the majority of cases with hypertension, the finer arterioles are sclerotic and narrowed, producing an increased peripheral resistance and putting a heavy load upon the heart muscle. Under this prolonged strain the heart eventually becomes decompensated and, in many cases, excessively enlarged.

Fatty infiltration or the fatty heart is a part of a general obesity. The heart is encased in an excessively thick layer of subpericardial fat, which may penetrate into the myocardium between the muscle layers and may even destroy them to some extent. The heart of an obese person not only works under the handicap of a weakened muscle, but must also furnish blood to a large surface area. This heavy burden further impairs the already weakened muscle to such an extent that it often breaks under the strain, thus accounting for the high mortality rate in obese individuals suffering with acute infections.

We have observed that many patients with long standing cholecystitis and others will prostatic hypertrophy and obstruction frequently develop myocardial disease. The absorption of toxins over a long period weakens the heart muscle. This condition was responsible for the former high mortality rate in surgical removal of the gall bladder and prostate. In recent years, however, the practice of strengthening the heart muscles by preoperative rest and fluids has reduced the mortality rate to a small percentage.

Symptoms—Breathlessness in some form is the most common symptom. The sensation is that of constriction in the chest and the desire to breathe deeply. Anyone who leads a sedentary life will have shortness of breath on moderate exertion, but if it occurs during the usual activities, myocardial weakness may be suspected. Dyspnoea will gradually be experienced more frequently and more readily until the attacks become severe, and eventually the patient may suffer even while resting. The attacks may awaken the patient from sound sleep with an abrupt onset and may be so severe as to constitute paroxysms very similar to those of bronchial asthma. Such paroxysms may be the first indications of cardiac failure. Cardiac hypertrophy is sometimes discovered before the appearance of breathlessness.

Hypertrophy—Physical examination shows, with a few exceptions, an enlarged heart as the most significant departure from the normal. As a rule, this can be detected by palpation, percussion, and auscultation, although in obese persons the fluoroscope may be required to determine definitely the size of the heart. Slight enlargement without symptoms has no real clinical significance.

In a few patients of this group the heart is not enlarged; muscle failure seems to have taken place without muscle hypertrophy. A fibrous myocarditis with atrophy of the muscle is more probable.

Heart Sounds—The earlier teachers of medicine emphasized the various heart sounds and murmurs and believed them to be of great diagnostic importance. It is natural to assume that changes in the heart sounds would be present in myocardial disease. Faint heart sounds, however, may result from a weakened myocardium, from a thick or deformed chest wall, or from an increase in the overlying pulmonary tissue; alone, therefore, they are not diagnostic.

The presence of heart murmurs is often misleading. In fact, heart murmurs play a very small part in the diagnosis, prognosis, and treatment of myocardial disease. In patients with hypertension and myocardial disease, a low pitched diastolic murmur may be heard at the base, or occasionally over the aortic or pulmonic area. Autopsies on these patients have failed to reveal any evidence of disease of the valves. We should bear in mind that in advanced myocardial insufficiency the heart sounds are often unchanged and murmurs are entirely absent. On account of our early teaching, it is difficult to become reconciled to the fact that normal hearts may produce loud systolic murmurs and diseased hearts may show no variation from the normal. A safe rule to follow is to disregard heart murmurs unless other clinical evidence of disease is found. Certain types of nervous patients are inclined to worry if they know of the presence of heart murmurs, and it is best that they be uninformed of the fact if no other clinical manifestations of heart disease are revealed.

Rate and Rhythm—Cardiac failure is usually accompanied by tachycardia, but until the advanced stage is reached, tachycardia is present only on exertion. Rapid heart at rest is unusual except in very advanced heart failure or in an associated hyperthyroidism, arrhythmia, or both. A rapid rate with regular rhythm, if not paroxysmal, is probably due to hyperthyroidism.

Auricular and ventricular fibrillation, or rapidity with irregularity, are quite common and are the most serious complications of myocardial disease. Gallop rhythm also strongly suggests a weakened myocardium.

Particularly important is the patient with chronic myocardial disease who, when waterlogged from decompensation, has very little or no tachycardia and normal cardiac rhythm. So often these findings lead to a mistaken diagnosis of chronic nephritis and a treatment consequently incorrect. I recently had such a patient. He had been dieted, purged, and sweated until he was practically exhausted. When proper rest, digitalis, and a liberal diet were instituted, an immediate and rapid improvement was observed.

The electrocardiogram is most valuable in the detection of certain changes in the heart muscle which physical examination may not show. An inverson of the T waves and the distortion of the up and down stroke, such as widening, thickening and slurring, are indicative of a more serious prognosis.

Pulse—As a rule, the pulse gives very little information concerning heart function. Since many of these patients have hypertension, the tension of the pulse is usually increased. Pulsus alterans, when present, is of grave significance. It is best detected by the blood pressure cuff. At the high systolic level only part of the beats come through, but when the pressure is lowered the pulse becomes regular.

Edema—The peripheral signs of myocardial and chronic valvular disease are essentially the same. In the former, however, the edema is more pronounced and is especially apparent in the dependent portions of the extremities. The lungs and liver may become passively congested in advanced cases.

Often nephritis is a complication, and while circulatory disturbance persists, the urine is decreased in amount, dark in color, and contains considerable albumin, casts, and red blood cells. Under proper treatment to improve circulation and diuretics to relieve the retention of fluid, the urine clears up. The final picture depends upon the degree of nephritis actually coexistent with myocardial disease.

Pain—The majority of patients with myocardial disease have no pain. Angina occurs when arterial sclerosis with narrowing of the coronary vessels is associated. The character of the pain varies according to the extent to which the coronaries and vasa vasora of the aorta are involved; it may be a slight constriction of the chest on exertion or a severe, agonizing pain with foreboding of death. The paroxysms are accompanied by constriction in the chest and a sensation of smothering, yet dyspnoea may be very slight or wholly absent. The face usually becomes pale and the patient is enveloped in a profuse cold sweat, although, on the contrary, the face may become suffused from congestion. These attacks seem especially prone to follow exertion after a meal, probably because the diversion of a large proportion of blood to the splanchnic area reduces the supply to the heart. Ordinarily, the earlier attacks recur at long intervals, but as the disease progresses they become more and more frequent and are precipitated by decreasing degrees of effort.

Respiratory Rate—The respiratory rate is frequently irregular, particularly during sleep. With few exceptions, Cheyne-Stokes respiration develops during the latter stages of the disease and is very disturbing to the patient.

Cough—A dry, harsh cough appears late in the disease and is often sufficiently distressing to keep the patient awake at night. Pulmonary emphysema and chronic bronchitis may accompany the cough.

Diagnosis—The diagnosis of myocardial disease can usually be made with reasonable certainty before heart failure develops. It is based upon the history of certain acute infections, already mentioned, syphilis, hypertension. obesity, etc., on dyspnoea from moderate exertion, on the presence of an enlarged heart, and on electrocardiograph studies.

Myocardial disease must be differentiated from conditions characterized by somewhat analogous symptoms. General weakness and exhaustion following acute infections, wasting diseases, and anemias may be recognized by the close association of the causative factor. Chronic nephritis with edema may be distinguished by the distribution of the edema, by the urine analysis and kidney function tests. Chronic pulmonary disease in which dyspnoea is a symptom may be excluded by careful physical examination of the lungs. Effort syndrome occurs usually in young people with nervous exhaustion; in these the attacks of dyspnoea and cardiac pain appear while at rest, the heart is not enlarged, and the history is unlike that of myocardial disease.

Treatment—Preventive measures are becoming increasingly important in the treatment of heart failure. Their effectiveness varies according to the promptness with which they are instituted and the thoroughness with which they are carried out.

All chronic infections should be carefully eliminated. This can be done satisfactorily only if the patient is seen in the early stage of the disease. During the advanced stages the removal of infection may not only be of no benefit, but, on the contrary, may be very harmful. Constipation should be corrected; overindulgence in tea, coffee, alcohol, and tobacco should be avoided; the diet should be light, well balanced, and easily digestible.

Rest is of paramount importance. The heart reserve is diminshed and is rapidly depleted if the demands made upon it are frequent. The heart may recover from over-taxation many times, but the degree of its efficiency before each attack is not regained. For this reason, such measures as shortening of working hours, a period of afternoon bed rest, and plenty of sleep should be adopted early to prevent permanent strain. The length of rest periods must be determined by the degree of heart failure: the more advanced the disease, the longer and more frequent must be these rest periods. Complete and extended bed rest may be essential.

Physical and mental exertion, worry, anxiety, anger, and fear are potent factors in over-taxing an impaired heart. They should be controlled so far as is possible.

It is unwise to give drugs unless the heart has begun to fail. The practice of giving heart stimulants to patients who have heart murmurs or minor irregularities is to be strongly condemned.

When dyspnoea, exhaustion, palpitation, or other signs of heart failure are present, digitalis is the drug of choice. It is best given in sufficient dosage to digitalize the patient within three days; the amount should then be reduced or stopped altogether for a time. Two c. c. of a standard tincture, or two tablets of powdered leaves, given four times daily, will digitalize a patient of the average size within three days. The drug should be measured in c. c. rather than in drops. The drop method is inaccurate, as the size of the drop is regulated by the kind and size of dropper used. Usually, ten drops will equal about six to eight minims.

When the normal rhythm is disturbed, quinidin sulphate is beneficial. Three to five grains should be given four times daily until the irregularity disappears. Quinidin should not be administered following digitalis until the heart has become free from the digitalization. It is not so safe as digitalis and the patient should be carefully watched during its administration.

Sedatives are usually necessary, particularly in advanced cases. Bromides, chloral, and barbital are effective in the majority. In the more severe conditions, accompanied by dyspnoea and cough, opiates should be freely used. Cardiac pain may be controlled by amyl nitrite or nitroglycerin. All patients who suffer with angina should carry both of these drugs for use immediately at the onset of the pain.

In advanced myocardial disease due to syphilis, arsphenamine should never be used. It is unwise to employ any specific medication, in fact, until cardiac reserve has been built up by rest and other restoratives.

After advanced heart failure, from whatever cause, has been relieved, the patient should have a long period of rest in bed. Measures for prophylaxis and treatment of beginning failure should then be employed so far as is possible.

Our responsibility is, first, the prevention of cardiac disease and, second, careful management once the disease is established. It is highly important that we recognize the early signs of a failing heart. Treatment, to be of permanent benefit, must be instituted before decompensation occurs. For this reason, I wish to emphasize the necessity for a careful history and thorough examination of all patients who complain of irregularity of heart action or who suffer the least dyspnoea on exertion. The average patient will not voluntarily express himself on these points: one must ask direct and leading questions.

Next, instructions should always be given the patient concerning his general welfare and hygiene, the removal of foci of infection, the limitation of stress and strain on the cardiac and nervous systems, the correction of obesity, the necessity for prolonged convalescence from acute infections, the early, intensive, and prolonged treatment of syphilis, and the control of the diet.

Unfortunately, however, relativly few patients consult a physician until symptoms of failure have appeared. Early preventive treatment cannot become general until both laymen and physicians have learned to appreciate more fully the value of thorough periodic health examinations.

Read at the Houston Hospital Staff Meeting, June 23, 1931.

Acidosis

By DR. E. L. RICHARDSON,
Louisville, Miss.

By acidosis is meant an abnormal reduction of the alkaline reserve in the blood. The blood probably never becomes actually acid during life, but merely less alkaline. The depletion of the alkaline reserve is usually due to an excessive production of acids, but it may also result from a lessened excretion of these substances. The normal reaction of the blood is maintained (1) by the presence of alkaline salts, of which the most abundant is sodium bicarbonate; (2) by pulmonary ventilation, which serves to remove CO^2-the acid most abundantly formed in the body; (3) by the excretion of acid by the kidneys, partly in the free state, but mainly in the form of acid phosphate; and (4) by the formation of ammonia from the antecedents of urea and the elimination by the kidneys of acids in the form of ammonium salts. The primary effect of any depletion of the blood in fixed bases is a diminution in its capacity for carrying CO^2 and other acids. The accumulation of CO^2 in the tissues serves to stimulate the respiratory center, deepen the respirations and increase ventilation in the lungs. As a result of the increased pulmonary ventilation the tension of CO^2 is the alveolar air, and hence in the arterial blood, is diminished. The CO^2 tension in the alveolar air is, therefore, a measure of the extent to which the alkaline reserve of the blood is depleted. With the continued production of acids in excess the body defenses against acidity (pulmonary ventilation, excretion of acids by the kidneys, etc.) may in time break down and the depletion of fixed bases

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(Read at Hospital Staff Meeting, Houston, Miss.)

exceed the body's capacity for replacing them. In this event the blood becomes constantly less alkaline and finally so-called acid intoxication supervenes.

CAUSES OF ACIDOSIS—Acidosis may occur in the following diverse conditions: In starvation, following the continued use of a carbohydrate-free diet, in diabetes mellitus, in the toxemias of pregnancy, in surgical anesthesia, in advanced nephritis, in uncompensated cardiac diseases, in extensive lesions of the lungs, in acute yellow atrophy of the liver, in Asiatic cholera, in diseases associated with marked wasting, in poisoning by various drugs, including the heavy metals, phlorhizin, antipyrin and morphin, and in children in many different diseases, but especially in severe diarrhea, recurrent (cyclic) vomiting, and acute infections. The severe grades of acidosis (acid intoxication) however, are uncommon except in diabetes, the gastrointestinal intoxications of childhood, and some of the nephropathies.

THE ACIDS—The acids responsible for acidosis are not the same in all cases. The acidosis of starvation, meat-fat dieting, diabetes mellitus, surgical anesthesia and cyclic vomiting is due chiefly to an overproduction of acetone bodies—beta-oxybutyric acid, diacetic acid and acetone. On the other hand, the acidosis of nephritis apparently depends on the retention and accumulation in the blood of acid phosphates (Marriott and Howland), while that of certain pulmonary lesions seem to be the result of an excessive accumulation of CO^2.

The acetone bodies are produced by the incomplete oxidation of fatty acids derived either from fats or from amino-acids formed in the cleavage of proteins. By far the larger amount comes from fats. Diacetic acid is formed by the oxidation of beta-oxybutyric acid, although the process may be reversed, beta-oxybutyric acid being formed by the reduction of diacetic acid. The latter by yielding its CO^2 forms acetone. The toxic effects of beta-oxybutyric and diacetic acids in excess are due mainly to their acid properties, but it is possible that these acids may also exert a specific effect. Acetone is not an acid and is not markedly toxic.

SYMPTOMS—The milder forms of acidosis can be detected only by laboratory tests. Of the severer forms (acid intoxication), the most characteristic feature is excessively deep respiration ("air hunger") without cyanosis, due to a reduction in the blood capacity for transporting CO^2 and the pronounced stimulating effect of this acid in excess upon the respiratory center. In acidosis due to the acetone bodies there is also drowsiness deepening into coma. Headache and vomiting may occur, and in some cases there is a peculiar "fruity" or aromatic odor to the breath.

LABORATORY TESTS—In acidosis due to excessive production of acetone bodies, acetone, diacetic acid, and beta-oxybutyric acid may be detected in the urine by qualitative tests, but the presence of these bodies in the urine is not in itself proof of actual acid intoxication. Although acetone bodies are excreted in many diseases, their production is not often sufficient to cause serious untoward effects. Large amounts in the urine, however, especially in association with hyperpnea, usually presage coma. On the other hand, if the functional activity of the kidneys is impaired, as not rarely occurs in diabetes, there may be severe acidosis without acetonuria. Again, it must be remembered that in some other forms of acidosis, such as that of renal origin, acetone bodies to do appear in the urine. Acidosis due to acetone bodies may also be detected and roughly measured by estimating the ammonia content of the urine, although this method is defective in that it merely indicates the amount of acid and bases that is being excreted by the kidneys. The alkali tolerance test of Sellards is of considerable value, although it fails in the presence of cystitis with changes in the urinary reaction. It consists in ascertaining the amount of sodium bicarbonate that must be taken by the mouth in order to render the urine alkaline. About 5 gm. suffices in normal adults, but when acidosis is present two, three, or even five times that amount may be required. More accurate methods of estimating the degree of acidosis are the Marriott method of determining the CO^2 tension in the alveolar air and the Van Slyke method of determining the bicarbonate content of the blood. The Marriott method, although somewhat less reliable than that of Van Slyke, is comparatively simple and can be carried out in a few minutes.

PROGNOSIS—In general the severer grades of acidosis offer an unfavorable prognosis. Diabetic acidosis with coma is almost invariably fatal. Although consciousness is sometimes restored, the patient very rarely survives for a longer period than a few days or weeks. In the severe acidosis of chronic nephritis the outlook is also very grave. On the other hand, certain acidoses of childhood are frequently recovered from prompt and appropriate treatment.

TREATMENT—The first indication is to prevent, as far as possible, the further production of acids. Thus, in fasting, feeding should be instituted at once or, if coma is actually impending and the patient has been on an ordinary diet, a moderate amount of carbohydrate in the form of thin oat-meal gruel made with water (60 grams of oatmeal each 24 hours for a patient weighing 150 pounds) should be ordered. In the severe acidosis of cyclic vomiting, withdrawal of food (except dextrose) and colonic irrigation are important measures. Dextrose is apparently of service in all forms of acidosis except that due to diabetes. It may be given in 5 or 10 percent solution by the mouth, by the rectum or intravenously. Irrespective of the nature of acid intoxication, sodium bicarbonate seems to be helpful in replenishing the alkali reserve, although Joslin believes that it does more harm than good. It may be given by the mouth (4 to 6 grams or more in weak solution every two hours or by the rectum (3 to 5 percent solution). In urgent cases, however, it is best given intravenously (not subcutaneously) in 4 percent solution made with freshly sterilized water. For an adult 500 mils or more may be injected every few hours. A neutral reaction of the urine or, better, a normal blood CO2 reading, is an indication that sufficient alkali has been given. Solutions of sodium bicarbonate should not be boiled as the heat tends to transform the bicarbonate into carbonate, which is injurious. Whether alkali is used or not, a large amount of fluid (1000 mils within each 6 hours) should be prescribed. The fluid may be taken by the mouth as water, tea, coffee or thin broths, or by the rectum, or intravenously in the form of normal saline solution. Nausea must be avoided and every effort that excites it should be suspended. Free evacuation of the bowels is necessary and may be secured by calomel and salts or by enema.

For children large doses of potassium citratis, Sodium Citratis, in aquae menth pip, or cinnamon water. For adults citro-carbonate (Upjohns) may be used frequently and in large doses and encouragement of orange juice, grape fruit juice, tomato juice and lots of water if the patient can retain it.

IN MEMORIAM

JOHN OSBORN POLAK

March 12, 1870—June 29, 1931

With the death of John Osborn Polak on June 29, there passed an outstanding physician, teacher and citizen. He died as he had wished, "on the job"—suddenly, without apparent warning and without bodily pain. He was at the height of his very active and useful career, never more enthusiastic and hopeful in the consummation of the many important problems that he had planned for the future. He had no hobby save his task satisfactorily performed.

If John Polak had a guiding creed it must have been that proposed by Dean Briggs when he said, "Do your work—not just your work and no more, but a little more for the lavishing's sake; that little more that is worth all the rest. And if you suffer as you must, and if you doubt as you must, do your work. Put your heart into it and the sky will clear. Then out of your very doubt and suffering will be born the supreme joy of life."

His stimulating personality and indefatigable ability for work made those associated with him strive to always do better and better work. Leadership was a natural talent of John Polak's. He inspired enthusiasm and stimulated ambition. He commanded respect.

Dr. John Osborn Polak was born in Brooklyn, New York, March 12, 1870. His father was Karl Theodore Polak and his mother Mary Elizabeth Osborn Polak, whose family lived on Clinton Avenue, Brooklyn, for more than 100 years. He married Bertha Louise Pitkin on June 12, 1896—a lovable, kindly and devoted helpmate, ever mindful of his health and comfort—truly a doctor's wife. She died in 1924. One child—a daughter, Mary Osborn Polak—survives.

No citizen of Brooklyn was ever more proud of his "home town" than Dr. Polak. He was always "from Brooklyn" and was even on the alert for Brooklyn's best interests—medical, educational and civic. He gave freely of his time and money for the upbuilding of better medicine, higher standards of medical education and better civic conditions throughout the Borough of Brooklyn, and indeed throughout the nation. How he crowded the multiplicity of his interests into the "days of his life" still remains a mystery to those who knew him intimately.

Dr. Polak obtained his education at Rutgers Grammar School and from Rutgers College from which he received the Bachelor of Science degree in 1889 and the Master of Science in 1901. He was graduated in medicine from both the Long College Hospital of Brooklyn and the University of Vermont in 1891. He was awarded the Dudley Medal for Surgery upon his graduation from the Long Island College Hospital. Thus Dr. Polak, at the age of 21 years, began his medical career with signal attainments. With such a background it is little wonder that at the age of 61 years he had gained wealth, honor, and fame.

As a physician, Dr. Polak was kind-hearted, lovable, skillful; as an executive, able, equitable, sagacious; as a man, friendly, affable, inspiring—truly a gentleman. He had countless admirers—yes, many friends—all over the world. He was equally well known in the East, West, North and South.

As a teacher he was forceful, explicit, impressive. He had many loyal friends amongst his ex-students. His "boys" were ever dear to his heart. They had received instruction from him; he had received stimulation from them. One of his "boys" wrote in the "1931 Lichonian," the student yearbook of the Long Island College of Medicine, the following—"For twenty-five years his eyes have been directed toward the future while his hand and mind have dealt with the present and his heart has opened to his 'boys.' For twenty-five years he has carried the College on the crest of his fame and he has been the dynamic factor in every advance it has made. For twenty-five years he has sent his students into practice with a confidence born of his teachings. His name and that of the College are synonymous. Where Gynecology and Obstetrics are practiced his name is a byword. His surgical skill is tradition and his teaching is the model for thousands who are emulating him."

The world, unfortunately, is still heavily ladened with "charity patients" and Dr. Polak had his share of these—and more. He radiated sunshine and happiness to countless number of poor, tired, sick and unhappy women. He thrilled in their appreciation of his encouragement. Dispensary and ward patients received from him the best he could give. He reveled in their gratitude. No private patient got more of him. Dr. Polak must have believed, with James Allen, that "there is no physician like cheerful thought for dissipating the ills of the body; there is no comforter to compare with good-will for the dispersing the shadows of grief and sorrow."

Dr. Polak lived a temperate life. He indulged in no excesses save his work. He died too young—far too young—for he might have accomplished even greater things had he lived through that useful decade just ahead of him. As with Jerome Bell, in the beautiful poem "Mystery," we wonder

"What is this mystery men call death?
My friend before me lies; in all save breath
He seems the same as yesterday. His face
So like to life, so calm, bears not a trace
Of that great change which all of us so dread.
I gaze upon him and say: He is not dead,
But sleeps: and soon he will arise and take
Me by the hand. I know he will awake
And smile on me as he did yesterday;
And he will have some gentle word to say,
Some kindly deed to do; for loving thought
Was warp and woof to which his life was wrought.
He is not dead. Such souls forever live
In boundless measure of the love they give."

—Harvey Burleson Matthews.

From American Journal of Obstetrics and Gynecology. August 1931.

Anesthesia, Importance, Selection And Art Of Administration*

By W. H. ANDERSON, M.D.
Booneville, Miss.

This paper is no effort at a symposium on anesthesia with a review of the literature and a statistical conclusion for any favorite agent. We shall simply attempt to state some practical points gained mainly from our own experience with three to five hundred patients a year for the last ten years.

Vocal anesthesia is the oldest known. For thousandns of years it has been demonstrated in church and public forum. It reached its zenith perhaps in the New England States in Colonial days when it became necessary to station deacons in different sections of the church house with a rabbit's foot on a fishing cane to tickle the nose of the most deeply anesthetized, and more especially the ones with respiratory static. The lullabye of the black mammy with that constant rock and rhythmical vocal hush-a-byes one-half to one century ago was the drug of choice instead of the paregoric and multiplied hypnotics of today. Largely the same principles are demonstrated by the buzz of the automobile on the highway, the purr of the airplane, and the constant vibration of the distant and inaudible wheels of the approaching locomotive. We all know with sadness the anesthetizing effects of these. And we are also aware of the nerve-soothing and sleep-producing power of select instrumental music.

And as in restful sleep at night so in any form of surgical anesthesia, the proper environment is of the greatest importance. Sometimes what is music to one ear may be a disturbing noise to another. Two men sat on the banks of a large pond, one listening to the quack of the frogs while the other was bending his ear to catch every voice of the pack in the fox chase and each disturbed and infuriated at the pet nuisance of the other. In anesthesia we must learn to individualize the patient and to select the anesthetic best suited to the particular person and to the malady affecting him. One may have a great horror of going to sleep, losing consciousness; another has the same fear of being conscious while being operated upon. These feelings must be respected or the attitude changed, if the best results are to be accomplished.

Anesthesia has been the archangel of mercy to human suffering. It has made possible the development and the advancement of modern surgery which has relieved, which has cured, which has saved human life. It has coddled and protected the human organism from pain until it will no longer tolerate it, scarcely even the pain of a hypodermic needle.

The different types of anesthetics have multiplied until they are too numerous to discuss in one paper. We believe that from the ethylchlorid spray to amytal in the vein they have their indications. The average practitioner, the average local railroad surgeon, has neither the time nor the means to become fully acquainted with all of them. No anesthetic is without its faults. Anesthetics come and go to a certain degree as do the styles in dress.

At the present time in a large field of surgery spinal anesthesia is the most popular and is being very extensively used—and very successfully no doubt in a vast majority of cases. We believe it is here to stay in a certain field of surgery. Its use requires accuracy in the technic of injection and scrupulous care in the preparation and the handling of the solution. When the solution is in the cord it is in. If the patient should have an idiosyncrasy for the drug it presents an immediate problem of a serious nature. The spinal cord is very securely and divinely protected by columns of bony masonry and whether it will suffer repeated punctures and injections without injury to distal parts of the human organism is yet to be seen, and whether is can be universally used without a greater casualty list is yet to be determined. In some instances it will not put the patient to sleep, hence a supplemental anesthetic is required. Amytal by vein is the latest fad in anesthesia if we are permitted to use this term. This looks good. But again it does not produce a hundred per cent, anesthesia and here, too, the medecine is largely beyond our control when it goes into the vein.

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*Read before the thirty-fourth annual meeting of the Association of Surgeons of the Southern Railway System held in Chattanooga, Tenn., June 10, 11, 12, 1930.

This paper was awarded one of the three prizes for best papers read at this meeting.

For the average practitioner and general surgeon at the present time novocain or procain by the infiltration method, gas-oxygen, chloroform, and ether, these four, are the greatest, and the greatest one of all as yet is ether.

For removal of small tumors, tonsils, hemorrhoids and abdominal section, a 1 per cent. novocain with adrenalin is not to be surpassed. Adrenalin with novocain is of great value. It holds the novocain and gives better anesthesia, helps to prevent constitutional effect of the procain, and gives a clear field in which to work. The preparation of the solution is of the greatest importance. The ampules prepared by the best laboratory should be the only kind used by the average man. If the solution is not perfectly clear it should not be used under any circumstances. The type of needle used is of no small concern to the patient. You may tell a patient you will not hurt him, but when you come at him with a big needle with the point battered and rusty what you do to him in a minute will destroy more assurances than you can talk back into him in a year. The needle must be small, it must be sharp, it must be bright, and the beveled side turned to the skin, the skin have tension and pressure. The course of the nerve should be respected and followed from the proximal to the distal. The first prick of the needle, the wheel, should constitute about all the pain, and it will if time is given for it to take effect and to infiltrate ahead. A hurt is a hurt whether done with a needle or a knife. Entering the skin or a vein with the bevel of the needle turned up is like plowing with a bull-tongue plow turned backwards. You may say these points are too simple to be mentioned, maybe they are but they are of the greatest importance and they are being neglected by the average man. In the future a battered rough-pointed needle carelessly used will ruin your practice. It is just as important for a practitioner to know his needle and be artful in using it as it was for David to know how to use his slingshot. It will bring the same success.

Novocain and adrenalin is an ideal anesthetic for removal of tonsils. It gives a clear field in which to work, and post-operative hemorrhage and pneumonia are not so apt to occur. Twelve c.c. of 1 per cent. solution is the proper amount for the average case, this divided equally at upper and lower poles and on either side. It is of great importance to put this in the line of cleavage between the tonsil and the pillars with one stick going well behind the tonsil. One of the most common causes of post-operative hemorrhage is blood in the stomach. If the operation is completed and the patient put to bed lying on his face so that no blood will be swallowed a multitude of hemorrhage is saved. General anesthesia is as dangerous as calomel and dynamite in a case of intestinal obstruction. The infiltration method with procain works well for section of the abdominal wall.

Gas-oxygen has a large field of usefulness and the office of the average man should contain a couple of machines. For extraction of teeth in case of abscess and pyorrhea, gas-oxygen, and we prefer nitrous oxid, is the anesthetic of choice and this we believe should be administered by a physician. To administer gas well you must be well acquainted with your machine and of course must keep in mind the type of patient so as to gauge the amount and the mixture. One little point of great importance is to train your dentist to pull the easy tooth first, pulling the easy tooth first may cause just enough pain to make the patient breathe a little deeper and take the anesthetic better while pulling the hardest may "wake him up" in the beginning and give a lot of trouble. For bone felons, boils and carbuncles, ingrowing toe nails, curettements in incomplete abortion and a variety of other operations no anesthetic is so appropriate and nice as gas-oxygen. To administer gas successfully requires art, psychology, and judgment as in other fields of practice. The one biggest field for this anesthetic is in obstetrics. The mothers of our country have suffered too long and too much. We can give them some help with gas anesthesia. The automatic portable McKisson machine seems to be the most practical. We have rectal anesthesia, and twilight sleep, et cetera. They have their place and their indications. But the most practical for the average man in the small town is gas. It is safe, can be used in almost every case, and it is not as expensive as you have been told, six to eight dollars is about the average cost for the average patient. The machine is turned on and set, and any one can administer it, the patient can do it. If there is any one thing that the average practitioner needs to do in obstetrics it is to replace his pituitrin bag with a gas machine and to substitute for his baseball methods that are prolific with childbirth injuries and maternal lacerations a conservative method that helps to relieve pain, gives time, and prevents surgery and perhaps a high cancer death rate later. In your obstetrics use gas anesthesia and let your patient take it easy for a half day instead of touching a fuse and precipitating a labor in a thirty-minute dash.

About the same time more than seventy-five years ago, chloroform and ether began to be used in general anesthesia. Chloroform was discovered by a German scientist about the middle of the 18th century, and ether by our own Crawford W. Long of Georgia, in the year 1842. Chloroform has been extensively used, more generally perhaps than any other anesthetic. It has its indications and its strong points. In fact, we have patients who will hardly relax under any other anesthetic. Chloroform has, is, and may continue to be a great aid to the railroad surgeon. Fractures and dislocations constitute a large part of his practice and in those cases perfect relaxation is very essential. In obstetrical work chloroform may be used to a great advantage in the average case where gas cannot be had. The splendid relaxation at the time of delivery obtained by chloroform is a great aid in preventing pereneal lacerations. This anesthetic is a strong heart depressant and great caution and art is needed in its administration. The patient should be made to feel safe, should be fixed comfortably on the table, and the drop method used. The drops should be small and counted one by one to see if your work is being safely done. The jaws must be watched and held up and out.

Last in the discussion we come to ether, the anesthetic that has been so generally and so successfully used in the United States since its discovery by a southern man. Ether has been used in almost every type of case and by any and every one regardless of special training, and the casualties have been few indeed, comparatively speaking. The worst neglected art in the medical profession today is the administration of ether and chloroform, and especially of ether. Many people have gone to their graves because of the horror they had of going to sleep under ether and the nausea that was feared afterwards. This feeling should not exist, but the fault is ours. To put a patient across with ease and safety through a hazardous operation requires as much tact, talent, art and philosophy as is needed by any dramatist who has ever staged a play on Broadway or in London. It is not enough to know your ether. You must know your patient. You must take into consideration his psychological reactions to the ordeal he is to undergo. He must feel safe. He must be sure. You need anesthetic intuition and you must have a human heart that vibrates in sympathy with your patient. Beware of the man whom the child and the dog shun and to whom the cow refuses to give down her milk. In the presence of this type of man the patient fights sleep. When an ether anesthetic is to be given the stage should be set, no one little thing should be of little importance. The surgeon should realize that the anesthetist has his duty to perform to the patient and he should realize that the greatest importance is attached to the type of anesthetic the patient has, just enough for relaxation, but not one drop too much. Imagine yourself slipping up and putting under ether or chloroform a child who is in natural sleep without waking it and you will have an ideal. This can be done, it has been done. This example indicates to you how gentle, how careful, you should be in administering an anesthetic. No counting, no blowing, no deep breathing should ever be asked for. Make the patients comfortable. Explain to them that ether will not hurt if they breathe it quietly and easily and do not move. If the patient feels smothery, take off the cone and give him a little fresh air. It is important to have the ether can fixed so that you may drop as slowly or as fast as you like. Don't hold the patient in the excitement state too long. Pulling back on the chin cuts off the patient's breath, but holding the jaws up and out is a great boon to a good anesthetic. When the anesthetic is finished, see that your patient is conveyed to his room with care and that his head does not dangle and twist to cause a torticollis for months.

In the practice of medicine nothing is common or unimportant. The selection of the best anesthetic for the particular ailment of the particular patient is of utmost importance. Let us study. Let us think. Let us combine wisdom, judgment and art, stay doggedly on the job until we become more efficient in the neglected, but most scientific field of medicine, that of selecting and administering anesthetics.—International Journal of Medicine and Surgery, Oct. 1930.

Book Review

One of the most helpful books that has ever come to our desk for review is the Second Revised Edition of Diagnostic Methods and Interpretations in Internal Medicine, by Samuel A. Loewenberg, M.D., F A.C.P., of Philadelphia. Dr. Loewenberg is Associate Professor of Medicine, Jefferson Medical College, Assistant Physician to the Jefferson Hospital, Visiting Physician to the Philadelphia General Hospital, The Northern Liberties Hospital and the Eagleville Sanatorium for Consumptives. He first takes up history taking. He gives a simple, but complete outline for this. He then takes up the physical examination in all of its phases step by step in all of its divisions. He covers the subject, but never a word too much. Many illustrations are used throughout the book to aid in the interpretation of the diagnosis and to aid the student in making examinations on any and all patients. He gives much attention to topographic and regional anatomy, makes it most interesting and most helpful. The chapter on radiography by Leon Solis-Choen M.D. is very helpful. His interpretation of laboratory findings is most illuminating. The last chapter on Physical Examinations as Applied to Industry, Life Insurance, Health Preservation, and the Detection of Malingering all of which are unique and fascinating. The book from cover to cover is exhaustive in scientific fact, stimulating in thought and eloquent in expression. This is a most valuable book to every practitioner of medicine or surgery. It is just off the press. It is the last word. It is published by the F. A. Davis Company of Philadelphia. The price is ten dollars.

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1. Meeting Called to Order, Dr. C. E. Boyd, President.
2. Invocation, Dr. T. B. Bateman, First Presbyterian Church.
3. Reading and Adoption of Minutes, Last Session.
4. "Ureteral Strictures, Symptoms, Diagnosis and Treatment", Dr. L. C. Feemster, Jr. Discussion Opened by Drs. Morris and Philpot.
5. "Function of the Faucial Tonsil" Dr. D. W. Hamrick. Discussion opened by Drs. Dickson and Dotson.
6. "Tuberculosis of Infancy and Childhood wth Reference to Early Diagnosis and Tuberculin Reaction", Dr. S. P. Wainwright, Birmingham. General Discussion.
7. "The Business Side of Medicine", Dr. B. C. Tubb. Discussion opened by Drs. G. S. Bryan and J. W. Lipscomb.
8. Business Session.

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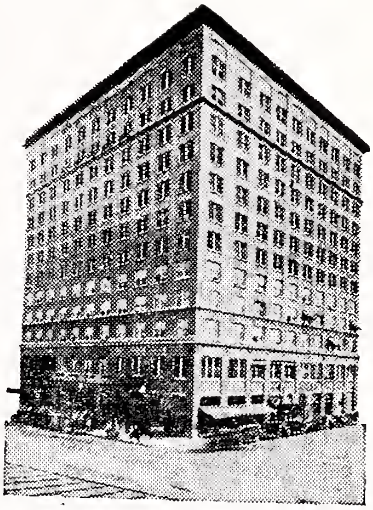

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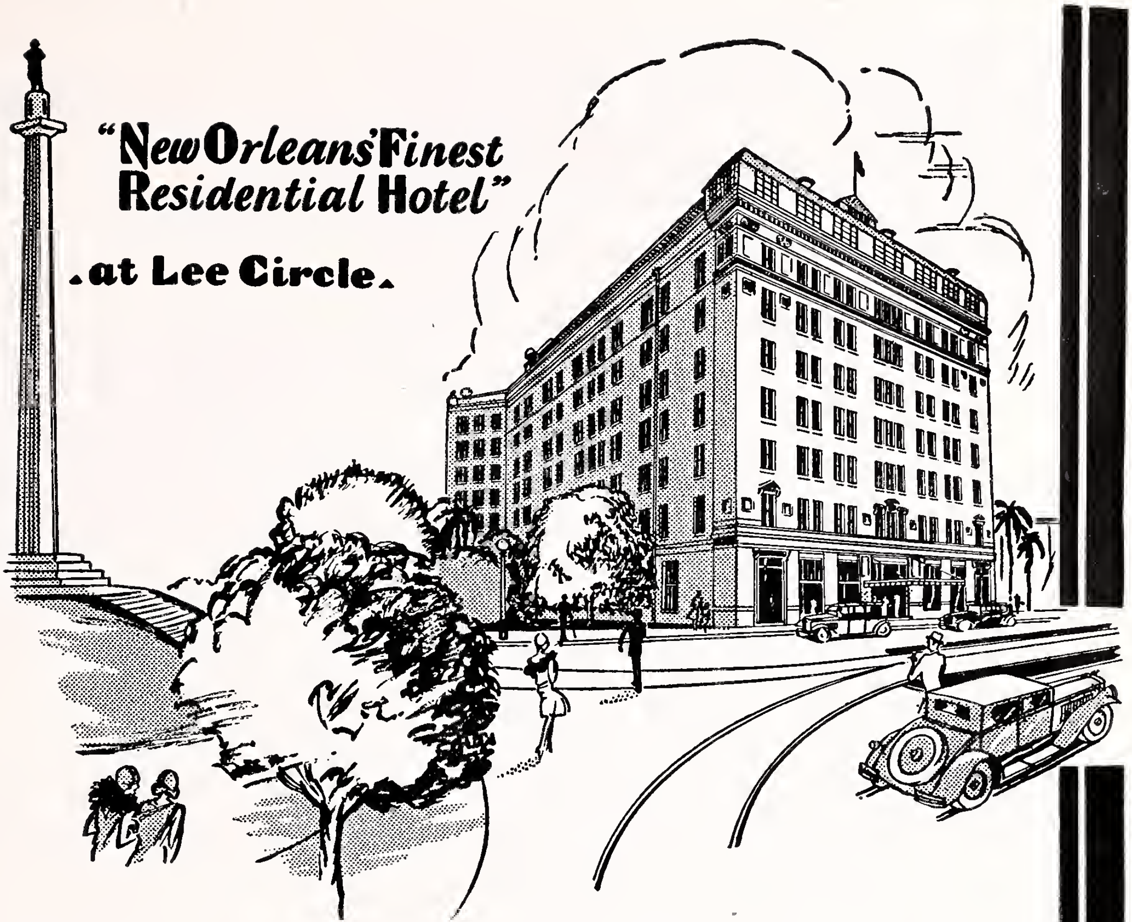
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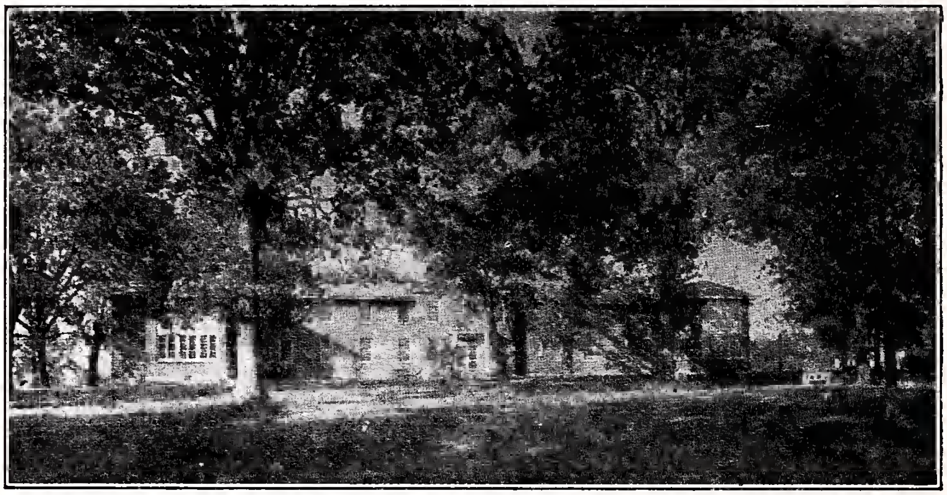

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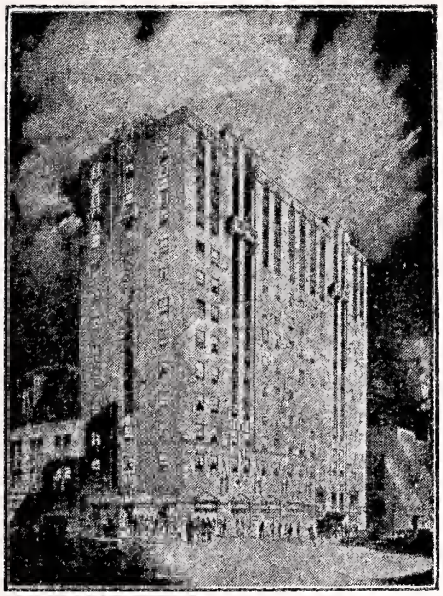

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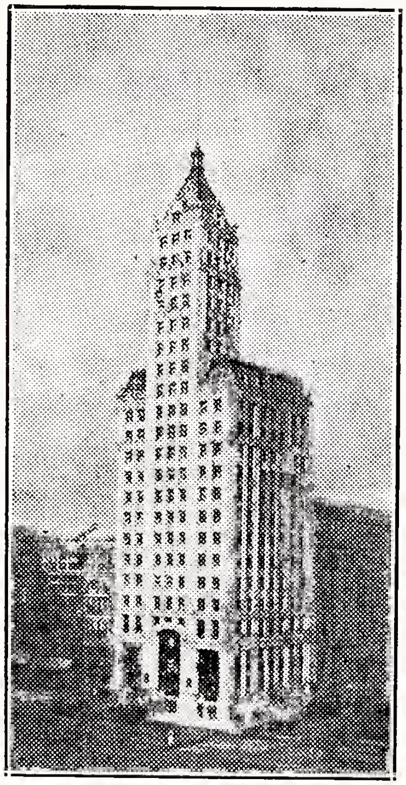

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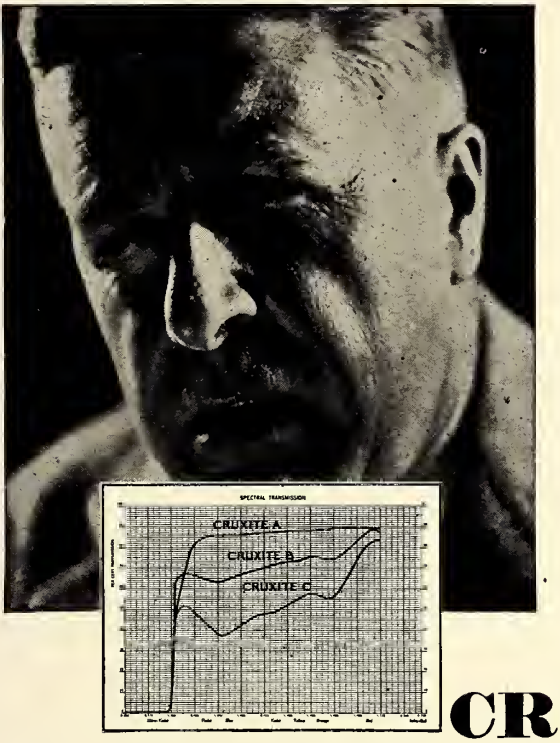

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THE MISSISSIPPI DOCTOR

VOL. 9. BOONEVILLE, MISSISSIPPI, OCTOBER, 1931 NO. 4

If--

(By Rudyard Kipling)

If you can keep your head when all about you
    Are losing theirs and blaming it on you;
If you can trust yourself when all men doubt you,
    But make allowance for their doubting, too:
If you can wait and not be tired by waiting,
    Or being lied about, don't deal in lies,
Or being hated don't give way to hating,
    And yet don't look too good, nor talk too wise;

If you can dream—and not make dreams your master;
    If you can think—and not make thoughts your aim;
If you can meet with Triumph and Disaster
    And treat those two impostors just the same;
If you can bear to hear the truth you've spoken
    Twisted by knaves to make a trap for fools,
Or watch the things you gave your life to, broken,
    And stoop and build 'em up with worn-out tools;

If you can make one heap of all your winnings
    And risk it on one turn of pitch-and-toss,
And lose, and start again at your beginnings,
    And never breathe a word about your loss;
If you can force your heart and nerve and sinew
    To serve your turn long after they are gone,
And so hold on when there is nothing in you
    Except the Will which says to them, 'Hold on!'

If you can talk with crowds and keep your virtue,
    Or walk with kings—nor lose the common touch;
If neither foes nor loving friends can hurt you;
    If all men count with you, but none too much;
If you can fill the unforgiving minute
    With sixty seconds' worth of distance run,
Yours is the Earth and everything that's in it,
    And—which is more—you'll be a Man, my son!

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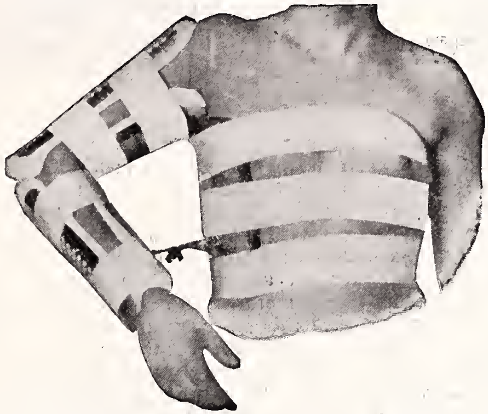

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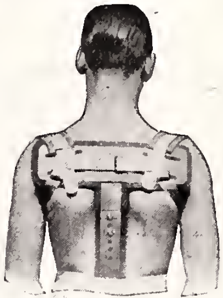

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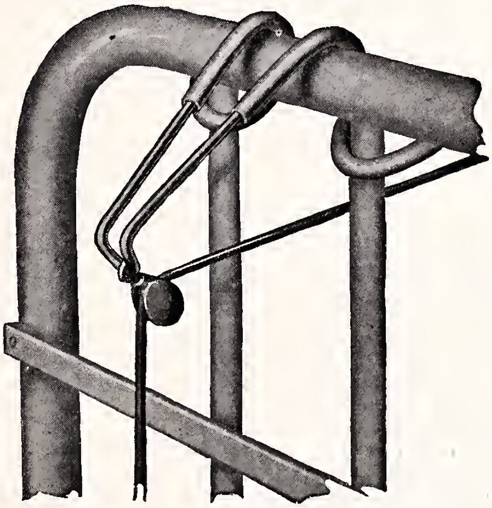

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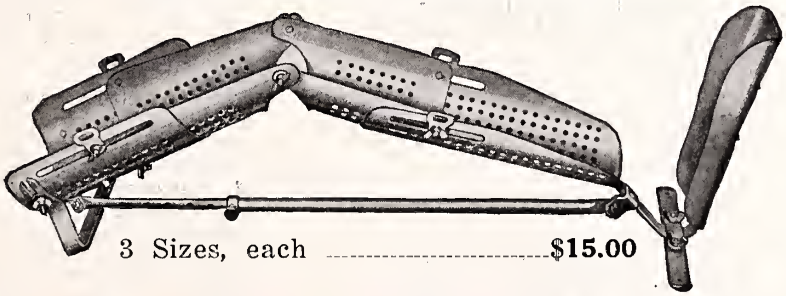

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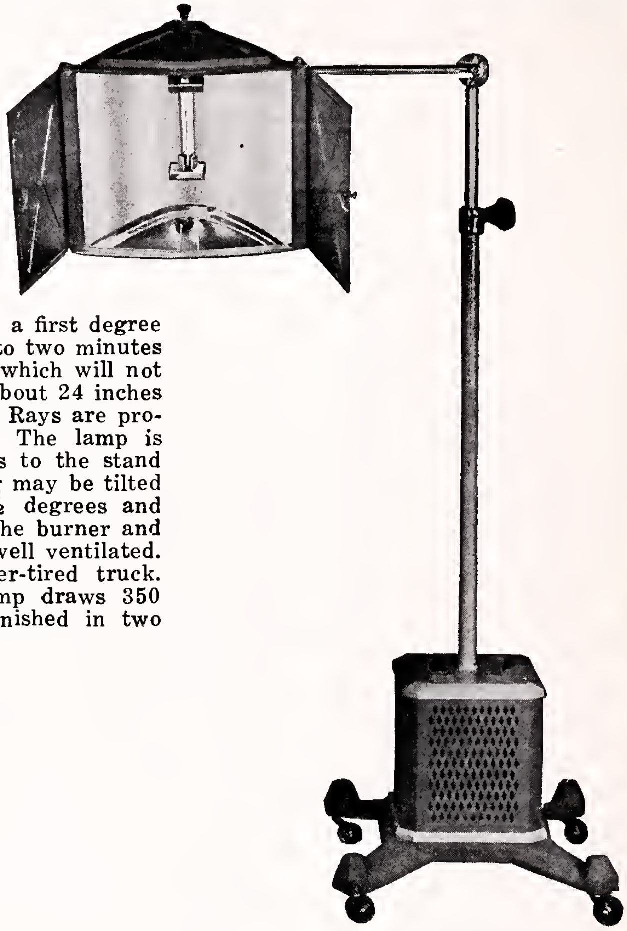

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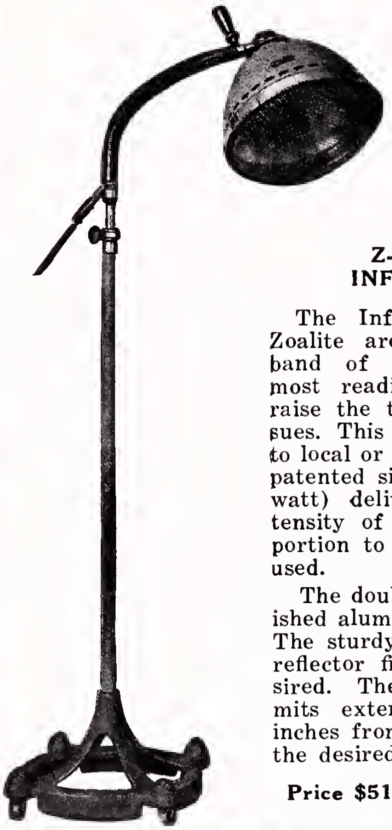

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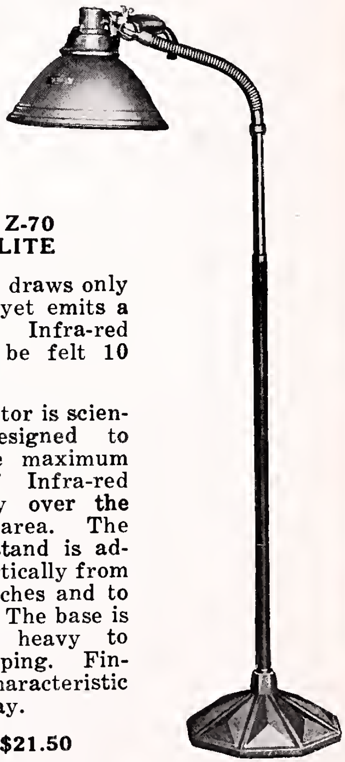

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THE MISSISSIPPI DOCTOR

OFFICIAL ORGAN OF THE NORTHEAST
MISSISSIPPI 13-COUNTY MEDICAL SOCIETY
—AND—
NORTH MISSISSIPPI 6-COUNTY MEDICAL
SOCIETY

W. H. ANDERSON, M. D., Editor and Manager

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We appreciate very much the new ad from the Robert E. Lee Hotel at Jackson, Miss. This is one of the very nicest and most up-to-date hotels in Mississippi, or in the South as to that. It is located in a quiet place and it is the last stroke for convenience. We are glad to carry an advertisement for this hotel. All Mississippians should feel a pride in a hotel like this.

You will note the full page advertisement of the Jung Hotel in New Orleans. This is rapidly becoming one of the most popular hotels of this great city. New Orleans is a wonderful city. Every person in this country should visit this city. The Southern Medical Association meets in New Orleans next month, the A. M. A. next spring. Keep in mind the Jung Hotel. Look in the Mississippi Doctor to pick your hotel.

Our next meeting will be held in Tupelo, the December meeting. It will be a good one we are sure.

Don't forget to set apart the 29th of October for Ole Miss day. Read the program and be convinced that you cannot afford to miss it.

The Medical Department at Ole Miss has rendered a fine service to Mississippi. We need to keep this medical course. Show your love for this department at Ole Miss and your loyalty to it by your presence on October 29th.

The only way to keep away from state medicine is that the profession to give the people the service that it is demanding. The clinic and the hospital must extend and it must multiply its services to the people.

Suppose you compare statistics of the small and the large hospital before you lowrate the small one.

The practitioner in the small town needs to refer one case in twenty to the real specialist in the city and the specialist in the city might do well to refer him about a dozen in the place of this one.

If the state pays for the actual charity in the small hospital, each patient will be treated by his home doctor in his home town near his own home. He will get as good or better service. The state saves money and the patient saves money and the distribution of physicians is made better and the efficiency of the medical profession is raised. You might as well try to run away from the sun as to get away from the benefits of this plan.

You will be sorry if you miss the get together good will meeting at Ole Miss on October 29.

The mental-motor type of man is the only one suited to practice medicine, the one active in body and in mind.

As education has been brought to the people so must modern medicine.

Always give big measure in service for what you expect in money. It is better to give more than you are paid for than less. Short service and long pay, generally speaking, is what is the matter with the world today.

We were exceedingly sorry to be unable to attend the Eighth Councilor's District Medical Society at Natchez last week. They presented a fine program. We are sure it was a fine meeting. Dr. J. C. Culley, President State Medical Association, and Dr. P. L. Mull, Dean of Ole Miss Medical Department were on the program.

Dr. J. C. Culley of Oxford is taking the lead on spinal anesthesia for Mississippi and surrounding states perhaps. In addition to the papers of the Northeast Mississippi 13 County Medical Society and the North Mississippi Six, we try to secure papers on subjects of the greatest interest to our readers and by men upon whom we can fully rely. Men interested in spinal anesthesia should read Dr. Culley's paper carefully and file it away for reference.

Dr. Bethea, of New Orleans, will bring you a message on October the 29th that will be profitable. Hear him at Ole Miss.

At our Columbus meeting Dr. B. C. Tubb wrote a good sensible paper on "The Business Side of Medicine". There is a business side to medicine. We should determine to give value received for everything we do. We should not be satisfied until we do our best. We should know the best as far as we go. And when we give service and know that we have, then we should expect pay for our services just the same as the grocery man does for his flour. The physician will always have to do some charity. If his heart does not incline to help the suffering who are unfortunate he should quit the practice of medicine. But we should not teach people that our services are not worth anything. Generally speaking the only help that is worth while is to help a man to help himself. People need to be taught that they must give when they receive, that their health is their greatest asset, but that it costs something. The earnest and competent general practitioner is the most poorly paid man of any profession. This can not continue. The general practitioner must keep himself informed, he must realize that he must make his profit on volume of business rather than a long price to the individual, and then he must be paid.

We appreciate the renewal of the half page ad by the American Optical Company. In addition to giving fine service, this company has good sense. Instead of sticking to an old set rule of not advertising in a local medical journal, it takes advantage of the best advertising in the United States for the money and keeps an ad in The Mississippi Doctor. It is mighty refreshing to see a big company like this act with real good sense.

You will read the paper of Dr. Wainwright of Birmingham with interest and profit on the Early Diagnosis of Tuberculosis in Infancy and Childhood. He gave the society a splendid treat. His paper and his presence were greatly appreciated. The society will look forward with pleasure to having him again.

Be sure to make your plans to meet us at Ole Miss on Thursday, October the 29th. It is a get together, good will meeting for the Ole Miss Medical school. This school has served well. Students who have graduated in the two years at Ole Miss have stood the test of examinations in other schools, before state boards and in the fields of practical medicine and surgery. This two-year course has been thorough. No matter how brilliant a student may be he has to work when he takes the two-year course in Medicine at Ole Miss. This is as it should be. He is trained to work. He is well grounded in the technical essentials of medicine. He is given fine ideals. He receives his training at much less cost than at other schools outside the state. He is taught loyalty to his home state. Ole Miss is a great university, regardless of what some may say. The two year medical course has not yet been surpassed. We want to keep this department. The young men of Mississippi need it. The people need for them to have it. Let us spend a day on the Ole Miss campus and get accquainted with our medical school and better acquainted with each other. Let us know each other better and love each other more because of our common interest in our medical school that has served our profession so nobly. The program to be rendered will be a great treat to you. It will be the best day you have spent up to date.

Be sure to read the very splendid and well written paper of Dr. D. W. Hamrick, of Corinth, on the Function of the Faucal Tonsil.

Dr. J. C. Culley, president of the Mississippi State Medical Association called the chairmen of the sections and Dr. Dye, the Secretary, to meet him in Jackson last week for the purpose of working out a program for our next meeting in May. He complimented them with a nice banquet at the Robert E. Lee Hotel. This was a fine idea. It will be worth a lot to the program. Papers will not overlap. One section should not have the advantage of another so much under this plan. This is a big step forward that should have been taken many years ago. Dr. Howard called the council to meet him last year. This was good, especially for the membership drive that he was especially interested in. A good well balanced program is of the very greatest importance. Dr. Culley's plan is the best yet enacted. Another general meeting in the early spring will still be very helpful we believe. Our state association has not been attended as well as it should and it has not rendered the service that it might have.

Community Hospitals

During the recent political campaign, many of the candidates stated that they were in favor of providing free beds for poor patients in every county hospital. Their ideas were somewhat at variance as to detail of ways and means.

At the recent meeting of the State Association at Jackson a resolution was adopted which provided for the appointment of a committee "To inform the public on the importance of this problem during the present campaign, in which a governor and members of the legislature are to be selected; to advise with the offer of assistance to our next legislative body in making the proper distribution of the state charity funds for hospitals; and to see that the hospitals measure up to the standards that will provide safety to the public."

This resolution was adopted without discussion and therefore the members of the House of Delegates, and the profession generally, are uninformed as to what is a proper distribution of the state charity funds for hospitals. In such places as Columbus, Hattiesburg, McComb, New Albany, Oxford and Philadelphia there are two hospitals. Does this committee intend to give to both institutions in these towns? Or if to but one how is the distinction to be made? Would it not be well to publish, at an early date, the standards by which the hospitals are to be measured?

The fund provided by the State at the present for the state charity hospitals is about a dollar a day per patient. The cost of caring for the patient in the small hospitals is not less than four dollars per day. Who is going to put up the other three dollars? Is the State to be asked to adopt a plan of caring for its indigent sick that will cost at least four times as much as its present method is costing?

This is not a defense of the state hospitals as at present maintained. In the first place the five state hospitals are located in a belt that extends from the Mississippi river at Vicksburg and Natchez to the eastern border of the state at Meridian and Laurel, thus leaving the whole northern half and the far southern section of the state out of reach in the case of emergencies. Secondly, for the past twenty-five years or more it has been the custom for each new governor to appoint a new board of trustees for each state institution. For many years it has been an accepted fact that the new board would appoint a new superintendent, who must be a surgeon. It is obvious that these constant changes dictated by political motives have interferred with the building up of an adequate staff at these institutions. As a matter of fact, in the majority of cases the superintendent has been more interested in doing surgery than he has been in superintending. It is evident, too, that in a hospital of a hundred beds or more where the superintendent in addition to caring for the business management of the hospital, must eat and sleep, it is a physical impossibility to give proper attention to all of the patients in an institution of this size. And it is equally evident that the direction and supervision of an intern staff without the aid of a visiting staff requires just as much of the superintendent's times as if he were to do the work himself.

On the other hand, it is a well known fact that in efficiently managed hospitals the per capita cost per day decreases as the number of patients cared for increases. At the present time much is being said about the cost of diagnosis and treatment, which has already mounted to an alarming figure. Will these small community hospitals be prepared to make a thorough diagnostic study at a cost that may be borne by the average man?

The questions asked above, it seems, should be given long and earnest consideration before the committee presents this matter to the Legislature. These smaller hospitals need aid as much as the five state institutions but unless the medical profession is prepared to offer a plan that will work smoothly and fairly for all hospitals and for the public we are more than likely to have forced on us some ill-considered plan prepared by a layman, which may prove to be another path leading to state medicine.

It is suggested that the Committee on Community Hospitals make a study of this matter before the Legislature meets. Let them study the plans for operating hospitals in Texas and Minnesota. With such data in hand this Committee would be in a position to present a bill to the Legislature that should be of real value. But this is of such importance that no report should be made until a modus operandi that will stand the test of time, and that will be fair both to patients and to physicians, shall have been adopted.

J. S. ULLMAN.

The above discourse and suggestions on the community hospitals appeared in the September issue of the New Orleans Medical and Surgical Journal. Our good friend seems to be craving light on the subject of community hospitals, but it is not quite sure that he has his eyes wide opened and turned to the East ready to receive. We are not a member of the hospital committee, but The Mississippi Doctor has been the champion of this idea for a good many years and for practically all of our medical life we have been thinking, talking and writing on this subject.

If we are correctly informed every candidate for governor favored aid for the small hospitals throughout the state. We feel sure that a very large percent of the legislators elect favor it also.

The resolution was adopted without discussion. It could have been discussed. It appears to us that it was so clearly written and was so unanimously favored that no one cared to discuss it. The Mississippi Doctor has carried articles on this subject at different times for about five years. The North East Mississippi 13 County Medical Society, The North Mississippi Six County, and the Delta Medical Society had discussed the plan fully and endorsed it one hundred percent before the state meeting. The resolution answers the question Dr. Ullman asked relative to aid for two hospitals in one town.

"We believe therefore that our next legislature should provide funds to care for the actual charity in all community hospitals in counties and sections of our state where no state hospital exists whether owned by a private individual, church, municipal or philanthropic organization, provided they are open hospitals and provided they measure up to standards that will insure safety to the people." This makes it plain that if there were a dozen hospitals in one small town that each one could receive pay for the charity patient it treats. No hospital is to be paid a lump sum regardless of the number of patients it admits. Our hospital committee, one man from each Congressional district, cooperating with a legislative committee will be able to lay down rules that will insure safety to the public, but at the same time will not be beyond the reach of the average small hospital of Mississippi. The standards can not be published yet because they have not been worked out. We have left this to our committee. This is the way we secure the laws of the land, elect representatives, and send them to Congress and abide by what they do.

"The funds provided by the State at present for the state charity hospitals is about a dollar a day per patient". It is conceded throughout the land that but few if any hospitals make a profit on the fees charged for caring for patients, the room rent and the operating room fees, et al. Now if our state charity hospitals can care so well for patients for one dollar every twenty four hours, they must know something that no other hospital in the entire world has learned. He states that the cost in the small hospitals is not less than four dollars a day. We can say for the North East Mississippi Hospital that it has never charged over three dollars for its best rooms and the wards only two. Had it occurred to you that some of the patients counted by the State Charity hospitals may not remain in the hospital over thirty minutes? We feel quite sure that the state hospitals are not caring for patients for one dollar per twenty four hours as a total and complete cost. This just wont stand the test of investigation. How about the big investment to begin with, how about the up-keep of the buildings and the equipment, how about the taxes on this property? And further more who is going to pay the railroad fare or the taxi fare for transporting the charity patient two hundred miles or even a hundred miles? This is expense. If it costs the individual in the end it costs the state. The hospital in the small town can be operated at less cost than in the large one in many ways. We do not know what rate will be decided on by the state for charity patients in the small hospitals, but we do know that the state can afford to pay quite a bit more to get it done in the hospital near the home of the patient. It will not have to invest in buildings and equipment and it will not be burdened with the inefficiency of the "spoils system". If the state pays for the actual charity asking for admittance to the small hospitals, it will enable private individuals, groups of individuals, or churches to own and operate these hospitals and will do more to keep us away from state medicine than any one thing and that can possibly be done. It will be our greatest means to secure a proper distribution of the profession. The cities are crowded, the rural communities are starving for modern medicine. The great and profound late Dr. Polak said in the March Issue of "The Mississippi Doctor", "The community hospital is the solution of modern medicine for the rural districts". Dr. Polak was born, lived, practised and died in Brooklyn, New York, and this is the way he felt about it. Will these small hospitals be prepared to make a thorough diagnostic study at a cost that may be borne by the average man? This is another question asked by Dr. Ullman. We will say in answer to this that they are doing it in fine style.

About one patient out of twenty needs to be referred to a specialist. When the average small hospital in Mississippi fails to render service to a patient he will have to refer him some where besides our state charity hospitals for better service. "The well trained general practitioner can do all that is necessary to diagnose and treat over ninety five percent of our cases. Only the more complicated matters should be referred"—Dr. Bullitt, October Issue New Orleans Medical and Surgical Journal. We have never put it quite this strong, but we have said for ten years repeatedly that eighty five percent of cases by the aid of the small hospital can and are being treated just as successfully as they would be any where in the world. We challenge our friend Ullman to disprove this statement by statistics. Recently Dr. Underwood has had Dr. McCord deliver a course of lectures at a number of the towns that have the small hospitals. This is a big step in the right direction. Here is only a foretaste of what is to follow. The small hospital will bring medical knowledge to the busy practitioner at his very door and he in turn will deliver it to a needy public. If the state pays for the actual charity coming to the small hospital, the profession can and should maintain the hospitals. The community hospital is to be our greatest bulwark against state medicine.

It is all right to investigate, to learn all we can, but neither Texas nor Minnesota have just what we are working on. We expect to lead the way. We have a personal, a moral and a professional right to institute a plan that will enable modern medicine to be delivered to the masses at less cost if we want to. We have the plan under way. It is going to be put into action and there need not be any fears about it. The Commonwealth Fund has started a big move for rural medicine. It will fit right in with out plans. "The Community Hospital is the solution of modern medicine for the rural districts." It will bring post graduate work to the profession. It will be delivered to the public at less cost. The small hospital throughout the country is to be our greatest means in delivering the modern curative and preventive medicine to the needy masses at a cost at which they can utilize it. Let the state pay for the actual charity and save one half what it is now paying and get better service. This is the biggest thing the profession in Mississippi has undertaken. Let us go forward and fear no evil.

Program

For Good Will Get Together Meeting
At Ole Miss

Thursday, October 29, 1931

Time: 10:30 A. M.

Place: University Chapel, Fulton Building

Address of Welcome—Chancellor J. N. Powers, University.

Response to Welcome Address, Dr. J. M. Acker, President Elect Mississippi State Medical Association—Aberdeen.

Some Recent Advances in Diagnosis of Lesions of the Chest—Lantern Slides—Dr. O. W. Bethea, New Orleans, La.

Significance of Blood and Pus in Urine—Dr. George R. Livermore, Memphis, Tenn.

Peptic Ulcer—Dr. Augustus Street, Vicksburg, Miss.

Paper—E. C. Ellett, Memphis, Tenn.

Speakers at Luncheon: Dr. O. W. Hyman, Dean of Medicine, University, Tenn.; Dr. P. L. Mull, Dean of Medicine, Ole Miss; Dr. Felix J. Underwood, President Southern Medical Association; Dr. J. C. Culley, President State Medical Association.

Program Committee: Drs. J. C. Culley, B. S. Guyton, A. H. Little (Secretary), R. B. Caldwell, and W. H. Anderson.

To be of use in the world is the only way to be happy.—Hans Anderson.

The Early Diagnosis of Tuberculosis in Infancy and Childhood

SAM P. WAINWRIGHT, M. D.
935 South 20th Street,
Birmingham, Ala.

The Pediatrician, as well as the general practitioner is often presented with a case having the following clinical symptoms: frequent colds, coughs, nervousness, anorexia, loss or failure to gain, fatigues easily, night sweats, lassitude and occasionally, slight elevations of temperature. The parents often suggest that maybe the child has worms, or if some relative had tuberculosis, however remote, they are uneasy on that account. The matter of the diagnosis of intestinal parasites is fairly easy to clear up by examining the stools, or therapeutically.

However, the diagnosis of tuberculosis in infancy and childhood requires much more diligence. To better emphasize this point, the recent work of Eberson, Delprat & Wolff bears this out. They examined 306 cases of suspected juvenile tuberculosis with reference to nine clinical symptoms, namely: the ones listed in the preceding paragraph; ten clinical signs, namely: D'Espine's sign, paravertebral dulness, malnutrition, dulness of the manubrium sterni, enlargement of the cervical lymph nodes, abnormalities of percussion and auscultation, phyctenular processes, involvement of bones and indications of tuberculos adenitis; and nine roentgen observations, namely: hilus calcification, increased lung markings, enlargement of bronchial nodes, thickening of interlobar pleura, thickening of the apical pleura, peribronchial infiltration, primary focus and parenchymal tuberculosis.

Of the series of 306 suspects, 206 gave a positive reaction to tuberculin; the remaining 100 were negative and, therefore, had never been infected with tuberculosis. The cases having a positive tuberculin were compared with the 100 having a negative tuberculin, with reference to the nine clinical symptoms; the ten clinical signs; and the nine roentgen observations.

They found that for the symptoms, the negative group gave 42% against 36.4%, that is, in the negative group from one to four symptoms were found in 42%, as against 36.4% in the positive group, in which three, five and six symptoms occurred.

Of the clinical signs, malnutrition, dulness over the manubrium sterni and enlargement of the cervical lymph nodes occurred more often in the positive group; while D'Espine's sign, paravertebral dulness and auscultation exceeded among those with negative reactions. Malnutrition was the outstanding clinical sign among the positive group.

The percentage giving histories of one or more roentgen observations was 94.2% in the positive and 85% in the negative group.

Certain outstanding physical evidence, such as; D'Espine's sign and paravertebral dulness was more prevalent in non-infected tuberculous individuals. Observations that in the past have been considered as pathognomonic of tuberculosis.

In final analysis evidence has been presented showing that commonly accepted clinical symptoms and signs have no diagnostic significance unless they are definitely correlated with a positive tuberculin test and roentgen observations that are positive for tuberculosis.

The tuberculin test is very little appreciated outside the realm of pediatrics. This minimizing of its importance by the medical profession is no doubt due to the earliest reports of the incidence of tuberculosis coming from Vienna, where tuberculosis is very high.

Surveys made in this country are naturally of most value to us. The first series in America reported by Veeder and Johnston from St. Louis, and Gittings and Donnelly from Philadelphia, gave a curve which was much lower than those from European cities, not over 45% at 13 to 14 years. Smith of New York reports a series of 7,668 children ranging from infancy to 13 years of age, in which 43% were positive to the Mantoux test.

In a series of my own in Washington, D. C., in 1926, I found that 26% had become infected before puberty.

In 1890, Koch introduced the general or subcutaneous tuberculin reaction. In 1902 Brauner noted a local skin reaction around the site of therapeutic injections of tuberculin.

Pirquet described his cutaneous scratch test in 1907; in the same year, Wolff-Eisner brought out the conjunctival test, and Morro introduced the percutaneous or inunction test. In 1908, Mantoux described the intracutaneous test.

While there have been several modification of the above tests, no noteworthy additions have been made to the above list. In all these tests, the essential principle is the same; the object being to bring tuberculin into contact with the deeper epithelial cells. The success of the tests depends entirely on the accuracy with which this contact is established, therefore, the Mantoux, or intracutaneous test should be expected to be more certain than any other test.

The question is asked—what does a positive tuberculin reaction mean? It means that the tubercle bacillus has lived and grown in the body. The best explanation for the reaction is that cells which have once been dosed with tuberculin from living tubercle bacilli develop the power to react when tuberculin is again brought into contact with them. The skin reaction allergen is probably intracellular, bound with the tissues. It is possible to sensitize local areas of skin by repeated tuberculin reactions, but the rest of the skin of the body will not react. General skin sensitivity is seen only after the tubercle bacillus has lived in the body, that is, after true tubercle formation.

Heretofore, the Pirquet or epidermal test has been used as a routine procedure. The essayist, who worked with Dr. Chas. Hendee Smith of the Children's Medical Division of Bellevue Hospital, feels sure that he is responsible for the developing and perfection of the Mantoux, or intracutaneous test. His tireless efforts in behalf of this test have resulted in almost complete abolition of the Pirquet test.

The Pirquet test has several distinct disadvantages. In the first place, it is not always easy to distinguish a true reaction from that due to trauma. If the scratch is too deep, there is often a little swelling around it, which may lead an untrained observer to call the reaction positive. Just as a vaccination may not take when performed by the epidermal method, so the Pirquet test may fail because the tuberculin was not kept in contact with the cells of the deeper layer of the skin long enough to excite the specific response. The inaccuracy of the Pirquet test is shown by the fact that many children will fail to react on the first test and yet, will show a positive reaction on a retest a few days later. This is not due to skin sensitivity, as the Montoux test gives a much higher percentage of positives. Moreover, if two Pirquet tests are made at the same time, one may fail to react and the other react sharply. If a single test is made and does not cause a reaction, it is necessary to repeat the test once or twice to be sure that the failure was not due to technical error.

Years of using a Pirquet on one forearm and a Mantoux on the other forearm resulted in so many more positive Mantoux reactions, that now, the Pirquet has been abandoned by Pediatricians.

The Mantoux, or intracutaneous test is performed by injecting into the epidermis a dilution of old tuberculin in salt solution. A small wheel must be made in the skin itself. The reaction appears in from 24 to 48 hours. The test should be read always after 48 hours and on the 5th day. A positive reaction varies from 1 cn to 12 cn in diameter. Occasionally, there is vesiculation; at times, a red streak following the lymphatics up the arm. No harm results from this.

The Mantoux test is much more certain than the Pirquet, because the tuberculin is injected into the exact layer of cells which react, and cannot be wiped off as in the epidermal method.

The dilution used must be made up accurately. The dilution that has proven most satisfactory is the (1:1000) dilution.

The initial dose of O. l mg. The 1:1000 solution makes the calculation easy, and this is important because medical men are not, as a rule, reliable arithmeticians O.l c. c. of 1:1000 solution equals O.l mg. of old tuberculin. O.5 c.c. of a 1:1000 solution would represent O.5 mg. of old tuberculin. If the physician, in his office, will boil 100 c.c. of water, add a salt tablet and 0.l c.c. of tuberculin, he will have a fairly good solution. Several pharmaceutical houses are putting out outfits of measured tuberculin and diluent. Incidentally, if the preparation is kept in the ice box, it will be serviceable for at least a year after it is mixed. The initial dosage of 0.1 mg. of old tuberculin intradermally is that for a child; if any of you should try this on an adult, I would recommend that the initial test be 0.05 mg. The skin sensitivity is more marked in adults than in children.

As a rule, it is rarely necessary to perform more than two tests, except in cases in which there is some reason to suspect late tuberculosis, in which there is some depression of the skin sensitivity. If there is no reaction after the initial test, I wouldn't hesitate to make a large wheel on giving the second test.

In all febrile diseases, such as, measles, scarlet fever, influenza, chicken pox, etc., there is a lowered skin sensitivity; as shown by Mitchell & Eddy, who tested a large series of children in the sick wards of the Cincinnati General Hospital. They found almost three times as many positives in convalescent cases as when tested during the febrile period.

A control test to the Mantoux test is not necessary. Salt solution, or other inert solutions never cause a reaction which may be confused with that due to tuberculin.

In testing negroes, there is no difficulty in reading the reaction. The forearm is used, which is less pigmented than the outer surface of the arm. The reaction appears as follows: it is red, is of at least 1cn. in diameter, is elevated, slightly indurated, and increased in pigmentation over the reacting area.

In doing the Mantoux test, a special Luer tuberculin syringe is used. This syringe should be used for no other purpose than for the test, otherwise, reaction from other proteins injected might be obtained that would be confusing.

The size of the reaction furnishes no index as to the amount of infection or resistance. In other words, an individual with a small reaction, that is, 2 cn. in diameter may be infected as severely as another with a reacting area twice as large. Children having phylectenular conjunctivities; those subject to continual reinfection; and children of oriental parentage exhibit most sensitivity to tuberculin.

Casparis is of the opinion that sensitiveness to tuberculin in cases of phylectenular conjunctivities is probably due to a hypersensitiveness to tuberculin; and that the phylectenular process is itself a manifestation of this hypersensitiveness.

The surveys that have been made, with one or two exceptions, have been made in the charity hospitals of large centers and range from 40% to 50% infected. These institutions draw from the poorest class and naturally, the conditions under which the children of the poor live, in large cities, is conducive to the development of tuberculosis. Slater presented a survey made in a rural community in Minnesota, where the families were widely separated and hence, exposed to few persons outside their own families. Up to the age of 16 years, only 12% to 13% had been infected. The Pirquet test was used and this, undoubtedly, accounts for the low incidence, as Harrington and Myers in studies of 2118 Minneapolis school children found an incidence of infection that was slightly higher than the New York series, namely 43%. Recent series reported from Europe show curves but slightly higher than curves reported in this country. However, the curves for the two Austrian cities, Vienna and Gras, remain distinctly higher.

It is a hopeful sign to find the percentage of positive reactions so low. It means that American children are not all infected by the time of puberty. It also makes the tuberculin reaction an important one.

In private practice, one has to exercise a certain amount of diplomacy in performing this test, on account of tuberculophobia on the part of some parents. It is my policy to avoid telling the parents what I am doing, simply telling them that it is a test. Quite often they do not ask, or else they think it is some sort of test for bad blood. In cases on which I do a Schick test, I often slip this test in on the opposite forearm.

In cases where the child is brought in to be specificially examined for tuberculosis, usually on account of some member of the family having tuberculosis, then it isn't necessary to use subterfuge in doing the test, as their minds are already prepared for it.

When a child presents a positive test, I always request, or rather insist on a roentgen examination. This is very necessary, in order to prognose the case. Again, in the event a positive observation, or several positive observations are made, this initial plate helps in the comparison with future plates, as to healing, etc.

The younger a child is infected, the more guarded the prognosis should be. Formerly, it was almost a dictum that infants under 6 months of age giving a positive reaction were doomed.

This is not true. Gerstenberger and others have reported authentically proved cases that have recovered: that is, by the finding of acid-fast tubercle bacilli in the stomach washings which had been homogenized and centrifuged, and also from the stools.

In infants dying of tuberculosis, the usual terminus is from T. B. Meningitis. I have tested some 18 cases during the last days of the disease and was able to get a positive reaction in 12 cases. In those failing to respond, the skin had lost its turgor and was in folds.

The roentgenologist will tell you that from the plate it is often impossible to distinguish between broncho-pneumonia and miliary tuberculosis of the lung. The test in this instance would put one on his guard, as to the prognosis of the case.

In joint infections, it often gives the correct lead.

The value of tuberculin reaction is generally misunderstood by the medical profession. The impression exists that nearly all children are infected and, therefore, a positive reaction means little or nothing. This idea is based on the widely promulgated early European statistics, most of which correspond to the figures for Vienna. But, if the amount of infection is so much less in this country, then it is of the greatest importance that those children who are infected should be watched through childhood and guarded against the stress and strain of adolescence, when active or fatal tuberculosis is so apt to break out.

It must be remembered that "the army of the tuberculous is recruited from those infected in childhood" and "phthisis is the last verse of a song, the first of which was sung in the cradle." These infected children, then, who carry tubercle bacilli in their bronchial nodes, or elsewhere, are the ones who need early, correct diagnosis.

The Mantoux test provides the means of making it. It should be used on every child who is underweight, anaemic or languid, or who has an unexplained irregular fever.

These children with "tuberculous infection" so called have true incipient tuberculosis, latent or active.

Their disease is generally in lymphatic tissue, where it is easily encapsulated and where scar tissue does no great harm. Under intelligent, watchful care, they usually do well. When the disease has involved more important structures, such as the lungs, bones, or meninges, the damage is greater, the cure is more difficult or impossible, and the diagnosis has been made too late.

Patient Very Ill:

Charge, oh, doctor, charge your fee
Charge I'll pay whate'er it be
Skill like yours I know comes high
Only do not let me die
Get me out of this and I
Cash will ante instantly.

Patient Convalescing:

Cut, oh doctor, cut that fee
Cut or not a dime from me
I'm not a millionaire
But I'll do whate'er is square
Only make a bill that is fair
And I will settle presently.

Patient Well:

Book, oh doctor, book that fee
Charge I'll pay it futurely
When all other debts are paid
Or when again of death afraid
I will pay it grudgingly.

XXX

We are not judge enough to say just how much poetry there is in the above lines, but there is not any doubt about the amount of truth contained in them. Many can read these lines and see themselves as they really are.

Spinal Anesthesia

DR. J. C. CULLEY
Oxford, Miss.

Dear Dr. Anderson:

In reply to your request for an article on Spinal Anesthesia, I wish to ask your permission to simply give you the results of my actual experience in the past four years with this form of anesthesia, rather than to go into any scientific discussion, other than to embody in this paper what I had to say at the meeting of our State Society in 1930. At this meeting I presented a paper on "Controllable Spinal Anesthesia". Before reading the paper I was frankly expecting a great deal of adverse criticism but to my surprise, it was favorably received and while one or two who discussed it were not satisfied with the results they were getting, they did not condemn spinal block as an unsound procedure. The revival of spinal block as a popular form of anesthesia seems not to be limited to any particular locality. A glance at the programs of Medical Societies in any section of the country will reveal a discussion of this subject. The American Journal of Surgery of March 1931 includes nine articles on Spinal Anesthesia.

That this form of anesthesia is not accepted by the profession as a whole, as are Ether, Nitrous Oxide and Oxygen and Ethylene, is evidenced by the fact that patients, when they enter the hospital, state that their family physician has warned them not to let anyone give them "that spinal anesthetic," and in my own experience several have been told by their physicians that there is great danger of a permanent paralysis. It is proper and fitting that the profession should be very careful in attempting the use of any anesthetic unless they are capable of administering it successfully, but it is unfortunate that some members of the profession have seen fit to make statements to the laity in regard to something about which they have had very little, if any, experience. This is in no manner meant as a criticism of the general practitioner, but to illustrate I will give this experience which was mine several months ago. An old lady, sixty-five years of age was brought to me with suppurative appendicitis and every indication of a generalized peritonitis. She had a diseased heart, arteriosclerosis, and a severe nephritis, the urine being loaded with albumin and granular casts. Her first statement to me was that she had been warned not to allow anyone to give her a spinal anesthesia because it was dangerous. Here was a case in which, as I see it, an inhalation anesthesia was absolutely contraindicated. After explaining the advantages of a spinal block, she readily consented. The operation was done with perfect ease, the appendix being removed without disturbing any of the viscera. Drainage tubes were inserted after removing, by means of a suction apparatus, all the free seropurulent fluid in the cavity. The patient carried on a conversation with the nurses during the whole procedure. The distention, which was marked at the beginning, had entirely disappeared by the time she left the operating room. She made an uneventful recovery and through her I have been privileged to operate on three of her neighbors, one of whom had a ruptured appendix. All of these requested spinal anesthesia.

For the past few years many theories have been advanced as to the action of drugs introduced into the spinal canal, and various technics have been followed in an effort to secure anesthesia to a certain level. Various solutions of known specific gravity have been advocated so as to limit the direction of diffusion and thus safeguard the medulla from fatal depression. Chief among the obstacles hindering the more general adoption of spinal anesthesia as a routine procedure is, as expressed by Campbell in 1925, a prejudice wrought of ignorance of the method and its proper usage. One has only to read the papers and reports of Pitkin, Koster, Stout, Tendler and many others to be convinced that this form of anesthesia is not a dangerous procedure, if used intelligently and by one who has a thorough understanding of the anatomy of the spinal canal and the solution which he is using. There seems to be some difference of opinion as to the desirability of inducing diffusion to the upper limits of the canal. We are advised by some not to permit the dissemination high in the canal because of the resultant fall in blood pressure; while on the other hand, Koster states that experience has taught him that it is advisable to induce, rather than to guard against diffusion to the medulla and brain stem in order to secure anesthesia of the entire body. Those of you who have a dread of spinal anesthesia because of the sudden lowering of blood pressure and respiratory paralysis have only to read the article of Drs. Koster and Kasman in Surgery, Gynecology and Obstetrics of November, 1929, to be assured, if not wholly convinced, that your fears are unwarranted. My reason for mentioning Dr. Koster's paper is that he used Neocain crystals dissolved in the spinal fluid alone and governs the height of anesthesia by the amount of fluid withdrawn; that is, the greater amount of fluid withdrawn and reinjected the higher will be the diffusion. Pitkin, on the other hand, uses a solution of lighter specific gravity than the spinal fluid and depends for dissemination on the expansion of the agent in the canal and limits such diffusion by posture. Although I have used Spinocain in all my cases, I have not followed Pitkin's technic to the letter. This was because I soon learned that every case did not respond alike and I was confronted with an occasional one in which I failed to secure anesthesia to the desired level.

Before describing the various steps in my technic I feel that it would not be amiss to mention some of the important points in regard to the spinal fluid and the anatomy of the canal itself. The researches of Weed, Dandy, Blackfan, and Cushing have disclosed several noteworthy facts: 1. The site of formation of the interventricular fluid is the choroid plexuses. The perivascular arterial spaces are probably the site of production of additional fluid in the subarachnoid spaces. 2. The circulation or absorption is toward the venous sinuses and the perineural sheaths, which are mesothelial lined spaces surrounding every nerve at its exit from the cranial cavity or spinal canal. Spinal subarachnoid fluid is largely dependent on the cerebromeningeal source of origin and, although we can hardly speak of an actual current, the dissemination is at least caudal. 3 .The rate of cerebro-spinal secretion is variable, and in the presence of increased cerebral pressure or of subarachnoid and interventricular drainage the rate of formation is increased to an enormous degree. These facts must be kept in mind in every subarachnoid injection of anesthetizing fluids, and one should try to visualize the possible relationship of the injected material to the anatomic area into which it is being injected and what then becomes of it.

In the lumbar and lower thoracic region the ligamenta flava often form a deep groove as they unite near the median line. If one is not careful the needle, as it strikes the point will be deflected to the side. Through the ligamenta flava the point of the needle enters the epidural space. This important region is filled with fat and veins with very delicate walls. In the median line, however, this space is comparatively avascular. As the needle point passes through this region it strikes the spinal dura, which is moderately tough, fibroelastic membrane, the majority of the fibers of which are arranged in longi-tudinal bundles, which when pierced with a sharp cutting edge produces free communication for the exit of spinal fluid into the spidural space or easily distended subdural cavity. To prevent this Pitkin has devised a short beveled needle which forms a window in the dura and closes when the needle is withdrawn. Passing through the subdural space the needle then enters the subarachnoid space which is incompletely separated into four divisions by the almost continuous streams of dorsal and ventral nerve roots so that there is a dorsal and a ventral compartment and two lateral compartments. It is further divided into a more complete dorsal and ventral segment by the ligamentum denticulatum. This is an irregular cribriform membrane which separates the motor from the sensory roots. When the anesthetic solution is injected into the posterior compartment diffusion into the anterior compartment, where the anterior roots containing the vasomotor constrictor fibers, are located, is dependent to a certain extent upon the number and arrangement of the perforations in the separating ligaments. This, it can be seen if the needle is pushed through the posterior compartment and is forced through the nerve bundle forming the cauda equina into the anterior compartmentment more anterior roots will be affected and more vaso constrictors will be blocked and the resultant pressure will be greater.

When the anesthetic agent diffuses upward sufficiently high for abdominal operations the rami communicantes are paralyzed, thus paralyzing the corresponding sympathetics. This produces a dilatation of the splanchnic vessels and the accumulation in them of large amounts of blood. If a sufficient number of roots are blocked, thus intercepting impulses which supply vasoconstrictor stimuli to the vessels we may have such a fall in the pressure as not to be able to get manometric reading. With this marked dilatation of the abdominal vessels the venous return to the heart becomes so little that not sufficient blood is forced to the brain and we have a cerebral anemia with its symptoms of pallor, nausea, vomiting, profuse perspiration and weak, rapid pulse. If such a thing should occur during the operation or at any time after the injection of the anesthetic solution the only way in which it can be contracted is by use of the Trendelenberg position. The use of drugs is futile since the block has already been established. Any drug used would have to be depended upon to have its effect on the vasomotors. This, it cannot do because it is unable to pass the blockade. If drugs are to be relied upon at all they must be used before operation and a sufficient length of time allowed to get the full effect. For this purpose Ephedrine is the drug of choice. For the nauses which occurs sometimes immediately after the injection we have found that smelling aromatic spirits of ammonia will usually be of great benefit.

ARMAMENTARIUM

(A) Pitkin's Solution. "Spinocain": One to three cc of Pitkin's solution, each cc (not each ampoule) containing 100 mg. of novocain, Metz; strychnin sulphate, 1.1 mg.; amyloprolamin, 130 mg.; alcohol, 324 mg.; normal saline, q.s ad lcc.

(B) Novocain—ephedrin solution: This is a lcc ampoule which contains 50 mg. of ephedrin solution: This is a lcc ampoule which contains 50 mg. of ephedrin sulphate dissolved in 1% novocain.

(C) Two spinal puncture needles of 20 or 22 gauge.

(D) Two Luer-Lok syringes, one of two and one of four cc capacity.

(E) One hypodermic of the finest gauge obtainable. It should never be less than 27 gauge —it is with this needle that the patient feels his only pain.

TECHNIC OF ADMINISTRATION

I never administer the anesthetic except on the operating table. The patient is instructed to lie on the left side with the thighs flexed on his abdomen and the legs on the thighs. His hands are then folded over his knees and the fingers clasped together. This brings the chin and the knees together, the same time bending the spine so as to widen the spinous interspaces, rendering the puncture an easy procedure. With the patient in position, the head of the table is raised until the tiltometer shows a reading of seven to ten degrees. This part of my technic is different from any other that I have ever seen or read about. An area extending from the twelfth dorsal to the fifth lumbar is painted with iodine and alcohol. The site of puncture usually chosen is the second or third lumbar interspace. The 1% Novocain in lcc of the 3% Ephedrine solution is used to produce a wheal through which the puncture is to be made. Before withdrawing the needle the remaining solution is injected into the interspinous ligament. The spinal puncture is now made through the anesthetized area and the patient should feel no pain whatever. In making the puncture the needle should be kept at right angles to the long axis of the spine and in the mid-line. As soon as the dura is pierced there will be a snap or ping which one soon recognizes after a few punctures. The stylet is withdrawn and the fluid should drip freely from the needle. If it does not, the position of the needle should be changed or reinserted. The syringe containing spinocain is attached to the needle and spinal fluid drawn out, where it can be seen to flow along the most dependent portion of the syringe. If the fluid does not come out readily or if blood is in the fluid the injection should not be made. I always, in every case, draw out 2cc of spinal fluid, thus filling the syringe to the 4cc mark. Three cc of this amount are injected, leaving lcc in the syringe. I then draw out 3cc of the spinal fluid and inject the whole amount. This patient is immediately placed flat on his back and the abdomen prepared for operation with iodine and alcohol. Before the table has been further draped, however, the patient is tested to see how far anesthesia has extended. If an abdominal operation is done the head of the table is left elevated until the skin anesthesia reaches the umbilicus. The table is then placed in five degrees Trendelenberg and the operation begun. As the anesthesia rises the head is further lowered. Should difficulty be met in withdrawing fluid the second time, I simply inject whatever amount remains in the syringe and allow time to elapse for the anesthetic to ascend in the canal. On two occasions it has taken 25 minutes for this to take place. Usually, however, the patient is ready by the time the draping is completed.

The only change which I have made since my original paper is in the preliminary medication. I am still using Spinocain with uniformly excellent results and I see no reason for changing to any of the newer preparations. I know of a great many surgeons who are using Novocain crystals or Neocain in spinal fluid but from all reports they are getting some failures, just as they got with Spinocain. In my opinion, the failures we get with spinal anesthesias are due more to errors of technic than anything else.

In elective operations the preliminary medication is begun the night before. Let us suppose the surgical procedure is set for 8:30 A. M. At bedtime the night before a capsule of Sodium Amytal (Lilly) is given. This usually produces a restful sleep and keeps the patient from lying awake worrying about the operation. At 7:30 in the morning, one hour before the appointed time of operation two capsules of Sodium Amytal are given by mouth. At the same time ¾ gr. Ephedrine is given hypodermatically. At 8:15 ¼ gr. morphine is administered by needle. This procedure usually brings the patient to the operating room in a drowsy semi-conscious state but sufficiently awake to co-operate in the further steps of the anesthesia and yet they usually go to sleep during the operation.

POST OPERATIVE CARE

As soon as the operation is completed the patient is returned to his room and the foot of the bed is elevated and allowed to remain so until sensation has returned to the lower extremities. When the patient begins to feel any pain whatever in the wound or in the lower extremities a hypodermic of Codeine or Morphine is given. Water, coca cola or ginger ale is allowed in small quantities to allay thirst. Further post operative care should be the same as that following any other form of anesthesia.

The paramount object of any form of anesthesia is to secure the greatest relaxation in the tissues with the least amount of danger to the patient. In the past mortality from spinal anesthesia was so great as to cause its discontinuance for a time but for the past few years the improvement in technic and the development of pure and stable drugs have secured for this form of anesthesia a proper place in the armamentarium of the surgeon. Mortality statistics on spinal anesthesia are difficult to collect. Certain deaths which have been recorded under its use can in no way be attributed to the use of the anesthetic. Rygh and Besseen in Minn. Medicine 11:744, 1928 have the following to say, "Present indications are that spinal anesthesia will eventually supplant other anesthetics for all operations below the diaphragm." Campbell in reporting results at Bellevue Hospital states that, "A comparison of our mortality with general and spinal reveals a difference of about 4% in favor of spinal." In a recapitulation of 326,910 cases Tendler found a mortality rate of one in 4,086 cases. In reviewing these cases critically, the greater number of these deaths were in cases where approaching death was plainly evident and death would have been inevitable no matter what anesthesia had been induced. For the past four years I have used Spinocain with no deaths. I carefully watch every step and keep accurate records as to blood pressure, pulse, respiration, extent and duration of anesthesia, etc. I had failure of the anesthetic in one case and inasmuch as the anesthesia was complete in the feet, I am sure that this was due to faulty position of the table. In three cases the anesthesia gave out because of the length of time we were operating and closure was done under gas and oxygen. One patient was unable to void and had to be catheterized for two weeks following the operation. This is sometimes the case following inhalation anesthesia. One patient complained of pain at the point of injection for three days following the operation. Not one has complained of headache. This is not in accord with Stout and Ewell who state that, "The method of Pitkin's was abandoned because of the occurrences of severe post operative headaches in a large proportion of the cases.

As for indications, I will make the rather broad assertion that spinal anesthesia should be used in practically all cases where inhalation anesthesia is contraindicated, and where in these cases the site of operation is below the diaphragm. The exceptions to the above would be a patient's idiosyncrasy to novocain, the meningitides, Potts disease, osteoarthritic spondylitis, and the fear on the part of the patient which cannot be allayed. I could not classify neurasthenia or low blood pressure as contraindications. It is very necessary to have present at every operation an anesthetist who understands fully every step in the administration of this form of anesthesia and who can meet any emergency which may arise. I give all my anesthesias but have on hand my regular anesthetist, who keeps his position at the head of the table to regulate the degree of Trendelenberg or Fowler as the case might be. His duty is also to watch for any unfavorable symptoms and to keep the patient's mind diverted. It is our custom to keep a cold cloth across the eyes of the patient and the anesthetist usually carries on a conversation to entertain him.

Since the report of my first series I have used Spinocain in 712 cases, bringing the total to 1213. In the last series I have not had a single failure, nor have we had any shock or complication.

I would like to call attention to one little detail which we have found most helpful, especially if the patient is to be transported any considerable distance from the operating room following the operation. The stretcher we use is of the four wheel tubular type, the top of which can be lifted off. We had made a swinging leg which can be hooked up out of the way when the top is flat but when released from the hook and the end of the stretcher top is raised this leg will fit against the end of the stretcher frame, thus holding the stretcher top on an inclined plane of about twenty degrees. Thus, when the patient is lifted from the table and placed on the stretcher the head is kept lower than the feet and as the bed has already been placed with the foot elevated, there is no danger at any time of a cerebral anemia. The bed is kept elevated until sensation has returned to the lower extremities. This is usually about two hours, and even after lowering the bed if the pulse becomes accelerated and the patient becomes restless the foot is again elevated.

The Business Side Of Medicine

DR. B. C. TUBB, M. D.
Smithville, Miss.

We have listened to several good professional papers, now let's look for a few minutes to the business side of medicine.

A paper which would cover this subject thoroughtly would be a kaleidoscope of many colors. Therefore, we can only touch the high points and offer the subject for discussion.

After finishing high school, a boy enters upon his medical course, spending seven years at hard study. With an out lay of from five to eight thousand dollars in money. Then he comes out of school at almost middle age, with only the foundation laid for his education.

He opens an office at considerable cost, then starts out to build a practice. He has nothing to sell but knowledge; yet he has more money invested than the average business man. He cannot cry out and advertise his wares, but must wait for some one to find him out and call upon him for service.

He must be more courteous than any one in the community, careful of speech, cannot talk about his patients especially those he sees in consultation, nor about a consultant to his patients. To do so usually means the loss of his patient, and the friendship of the doctor in consultation.

He must be true to himself and true to his clientele. To be true to himself he must be honest and render perfect service. To be true to his clientele he must be efficient, curing his patient in the shortest possible time, making his treatments pleasant and to suit the patient when possible.

He should have a workable system which will impress his patients, and enable him to accomplish things which he cannot accomplish without it. The man without system is hurried and pressed for time, rarely does very much, but goes round and round with very little accomplished in the end. He must grow in knowledge and go after larger jobs, with better equipment, able to assure his patients that he can do the work.

Unfortunately he sometimes comes in contact with a doctor who pays very little attention to rules of ethics, and is so self-craving he gets practice in any way he can. He cares not for the feelings or rights of other doctors or their patients. He is satisfied if he swims and the remainder of the profession sinks. He feels that he is a great success. The rule of doctors of this class is "Do unto others as they would do you, but do them first." These men soon ramble off into failure. The only remedy is preventative. Never forget right and we will never fall.

The man who knows little medicine, but keeps the golden rule: "Do not to others what they would not have others to to them" will come out far ahead of the well-versed man who travels for self alone, with little or no respect for his brother doctors.

There are thousands of little things which count in building up and maintaining a successful practice. But after we have done them all and spent our lives in service to poor suffering humanity, are we appreciated and paid for the time and money spent in our effort?

Our investment is in perishable stock. Many times we are called away, leaving the wife without money and our children ready for college. The earning has stopped. Then we wonder, since medicine is a profession, if it is a business? It is a business to the laity. Success in any vocation of life depends most upon health. Many men and women die of senile diseases at fifty or sixty years of age. We tell them how and what to eat, how to sleep and exercise. We prolong their usefulness, save their money, prevent the agony of pain and loss of life.

Then why don't we realize that medicine is a business, and that if a success is made money must be had to carry out the plan. We are so wrapped in our sympathies for the distressed that we forget ourselves and our families. We must change our course and make finance a part of the game. The lean months and hungry days must go. When we benefit others, we should benefit also. We improve health, decrease disease and make others comfortable, increasing their earning power. Then why not see that we are renumerated and made self-supporting, changing our ability into money power.

We may be a superior in healing the sick and bringing comfort to the afflicted, but when we die leaving no reward for our work it is whispered that we were a failure. For this reason, if no other, we should make medicine a business and save a sum for old age and declining years when we are unable to work.

Function of the Faucal Tonsil

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"A small almond-shaped mass between the pillars of the fauces on either side, composed mainly of lymphoid tissue, covered with mucous membrane, containing various crypts and many lymph follicles. They are believed to act as sources for the supply of phagocytes to the mouth and pharynx, which destroy bacteria entering the mouth." Dorland's Medical Dictionary, 14th Edition has this to say.

After a thorough perusal of the literature on the function of this lowly structure, I have about concluded that it is like the "Old Maid's Prayer": Often heard but never answered.

No tissue in the body has been the subject of more lengthy discussion, more theoretical conjecture, more investigation with fewer positive findings than the lowly tonsil and its purpose in the scheme of life.

According to the best authorities there are within our physical make-up certain atavistic or vestigial structures, which during some phase of our phylogenesis subserved a useful function, but with changes in diet, climate, mode of living, or what-not, now have no useful function in body metabolism-noteworthy among these is the vermiform appendix.

Does the faucal tonsil belong to this group of structures? Is it a part of the general lymphatic system of the body, or has it some special developmental, mechanical, or secretory function in the cycle of human life?

In the light of present knowledge let us consider the theories, known facts, and probabilities:

1. Rossbach considered the tonsil a secretory gland whose secretion contained an amylolytic ferment to help digest intaken food.
2. Bossworth thought it secreted plain mucous which acted as a lubricant in deglutition
3. Mink thought it secreted an inert fluid which moistened inhaled air.
4. Others thought the tonsils aspirated the excess of saliva, tears, and nasal secretions and returned them to the general circulation.
5. Allen & Wood maintained they were blood-building organs concerned in the histogenesis of white blood cells.
6. Massini thought they had some part in vaso-motor regulation, by means of an internal secretion.
7. Brieger & Gorke are the originators of the so-called defense theory. They claim: (1) That the tonsils possess a defense mechanism of their own, which renders them immune against infections, and (2) being situated at the most dangerous point, at the beginning of the alimentary and respiratory systems, act as a guard against the invasion of infectious diseases.
8. Schonneman, Berne and others thought the tonsil were regional lymph glands draining the nasal cavities, acting as a sort of filtering plant.
9. Stapler presents evidence in support of an internal secretory function interrelated with that of the hypophysis, thyroid, and ovary.
10. Are they concerned in the mechanism of active acquired immunity?
11. Are they concerned in pre-natal or post-natal development?

During Foetal life the dorsal extremity of the second visceral cleft enlarges forming a recess called the sinus tonsillaris. The upper part of this develops as the supra-tonsillar fossa, the lower part becomes first a smooth invagination of mucous membrane. About the fourth month of Foetal life downgrowths of epithelium takes place which afterwards becomes the tonsillar crypts. Lymph cells accumulate around these downgrowths, and form lymph tissue which at birth constitutes the mass of the organ.

At birth about 95% of all tonsils are imbedded, and remain so until about the third month of life. Between the ages of three and four years the tonsil reaches its greatest hypertrophy; somewhat dormant or recessive until about the tenth year it reaches another peak of hypertrophy. After that time there is no general rule, but there is rarely any hypertrophy beginning after the eighteenth year, the usual tendency being one of recession. These are the observations of Schonberger and Cronk working separately. Cronk observes also, that the two peaks of maximal tonsil hypertrophy are followed by corresponding maxima of weight increase, he concludes from this that increase in lymphoid tissue is a necessary preliminary to increases in weight. From these observations we can at least draw one conclusion: Simple hypertrophy is not necessarily an indication of a diseased tonsil. Wotzilka goes further, however, and states that when tonsil and adenoid hypertrophy becomes great enough to render respiration shallow and superficial, blood and lymph circulation in the lungs is rendered sluggish, and infections become more readily fixed in the intrathoracic lymphatics.

There is no peculiar anatomical or histological structure of the tonsil that sheds very much light on tonsillar function. The unit of tonsillar structure is the so-called germinal follicle, showing active mitosis near the center, and older lymph cells toward the periphery—the periphery being incompletely separated from adjoining follicles by trabeculae of connective tissue. They are covered over on their buccal surface by stratified collumnar epithelium which dips down to bound the fossulae tonsillaris or crypts. The blood supply to each unit runs in the connective tissue trabeculae.

That it is not a regional lymph gland we are reasonably certain. Typical lymph glands have a compact cortical substance traversed by a system of channels in which the lymph is flowing. They have afferent and efferent lymph vessels. It has been conclusively proved that the tonsil has no afferent lymph vessels, therefore it is not a part of the general lymphatic circulation. Having no afferent lymph vessels do they function as a filtering plant for infections entering by way of the nose and throat? That bacteria are caught in the crypts of the tonsils, we cannot deny—that they are not carried to the regional lymph nodes from these crypts, we are certain, if the epithelial covering is unbroken, since the lymphatics of the germinal follicles end in blind loops or cul-de-sacs in the lower layers of the epithelium lining the crypts. Are bacteria that find lodgement in these crypts destroyed? Lymphoid cells, or lymphocytes, have very little phagocytic action. Is tonsil hypertrophy a result of these infectious organisms, or do the tonsils them-

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selves become infected as a result of hypertrophy? This question has not been answered.

That the elaborate system of mucous glands in the connective tissue stroma secrete mucous which is emptied into the crypts is an accepted fact, but nearly all the other glandular structures in the body also contain mucous glands.

Are they blood-forming organs concerned in the histogenesis of white blood cells? That new-formed white blood cells of the lymphocytic series are being elaborated in the germinal follicles of the tonsils, we cannot deny, but according to the leading histologists most of these lymphocytes infiltrate through the epithelial covering, into the crypts, and find their way into the oral cavity, where they are found in the saliva, as "Salivary Corpuscles". Very few of them are found infiltrating in the other direction toward the connective tissue stroma which contains the larger blood and lymph vessels.

Are they glands of internal secretion? A review of our Histology shows us that all known glands of internal secretion have two constant characteristics which are absent in tonsillar structure: (1) A specialized type of epithelial cell, differing from the mass of the organ, showing a special staining so-called secretory granules. (2) A specialized type of blood supply in an intimate and fixed relationship to these specialized epithelial cells. So-called sinusoids, or open blood spaces separated from the specialized epithelial cells by only one layer of endothelium. These characteristics are common to the ovary, hypophysis, adrenal gland, pancreas, and spleen.

Are they vestigial structures? It is noteworthy that the more highly developed the organism, the more highly developed are the faucal tonsils, man being the most highly "tonsilized" being on earth.

I am now conducting a series of experiments with typhoid vaccine to determine if there is any difference in the time of appearance of a positive Widal reaction in tonsillectomized and non-tonsillectomized individuals, who have never before been vaccinated against typhoid. to try to determine if the tonsils play any demonstrable part in active immunity.

I do not know what the function of the faucal tonsil is. Some people can't get along with them, most every one seems able to get along without them. If you keep them you are apt to have hypertension, hypotension, Bright's disease, rheumatism, headaches, backaches, heartaches, pyelitis, arthritis, otalgia, myalgia, retinitis, gastritis, and sterility. If you have them out you may have all of these, and in addition a generous off-spring.

Was this night-blooming cereus type of flower at the top of the alimentary stalk meant to bloom and blush unseen in the deep unfathomed faucal caverns, or was it meant to be a "cut flower" to brighten and cheer our ailing bank accounts.

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The knowledge of today may be the ignorance of tomorrow. Then where are you unless you keep posted from day to day?—Leibnitz.

As a general rule the most successful man in life is the man who has the best information.—Disraeli.

Kind hearts are more than coronets,
And simple faith than Norman blood.—Tennyson.

The reason most men don't accomplish more is because they don't attempt more.—Thoreau.

The more we do, the more we can do. The busier we are, the more liesure we have.—Hazlitt.

A man to carry on a successful business must have imagination. He must see things as in a vision, a dream of the whole thing.—Charles M. Schwab.

To believe in the heroic makes heroes.—Disraeli.

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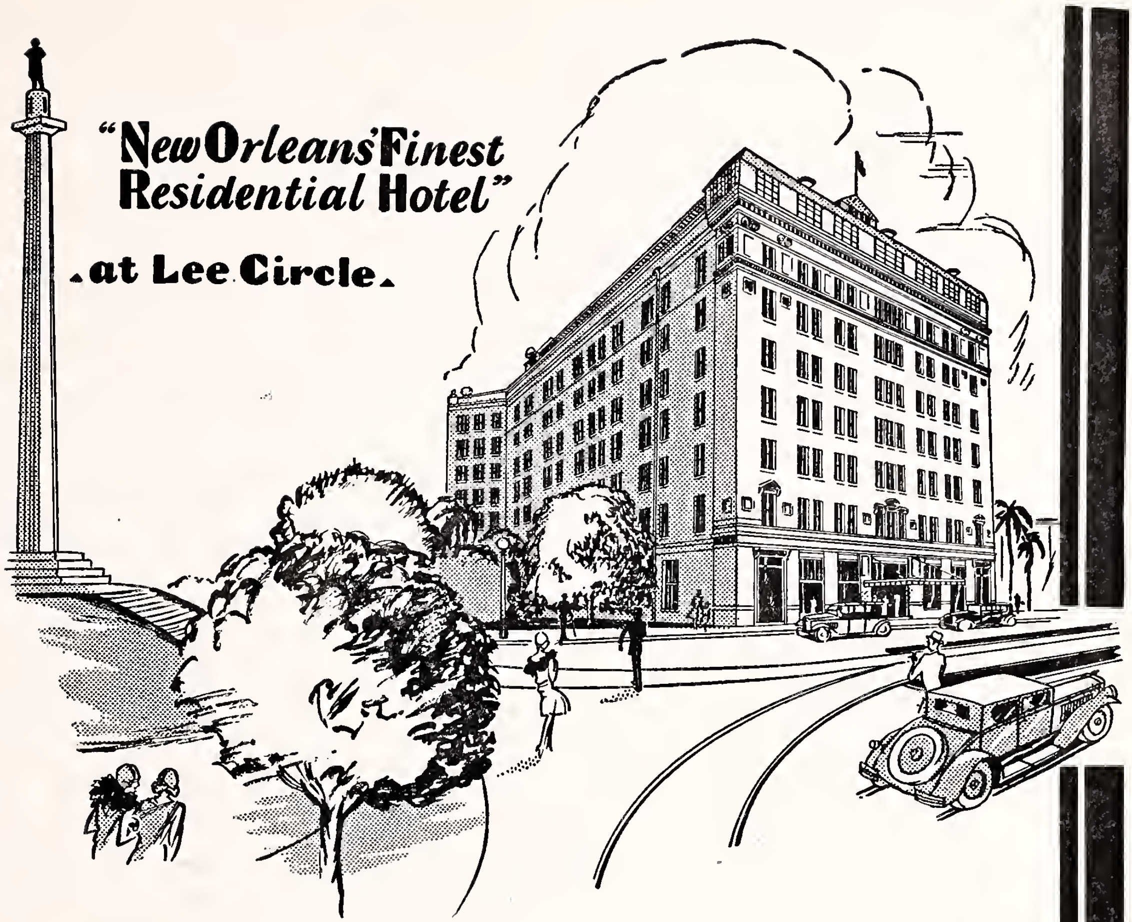

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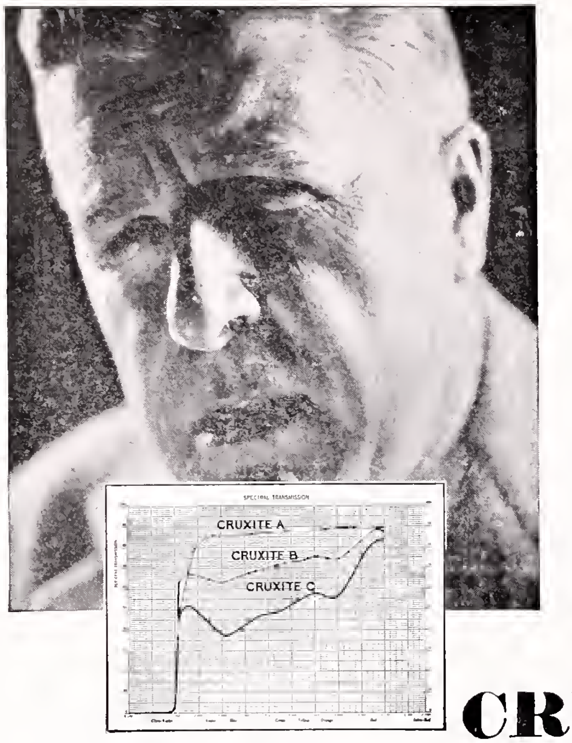

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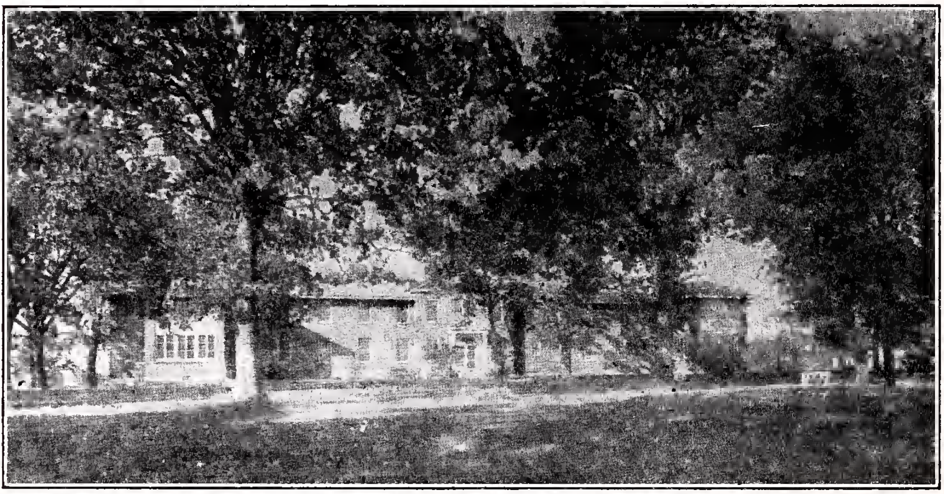

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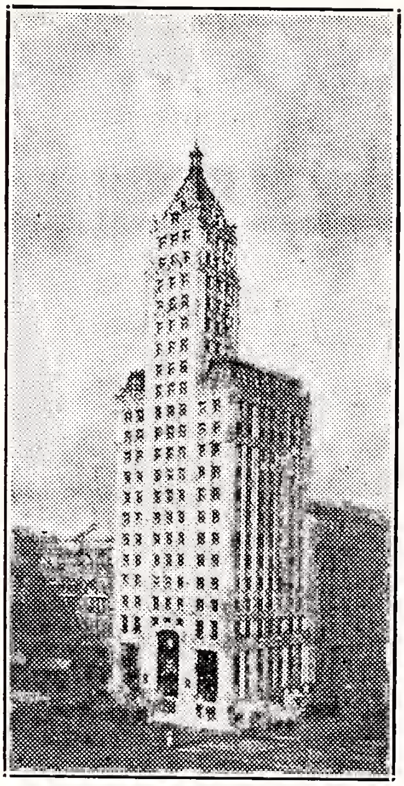

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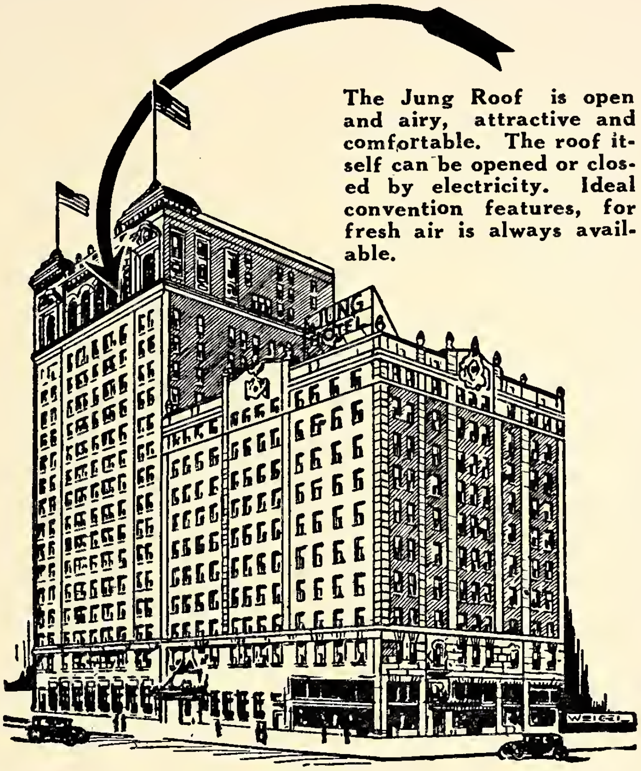

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VOL. 9. BOONEVILLE, MISSISSIPPI, NOVEMBER, 1931 NO. 5

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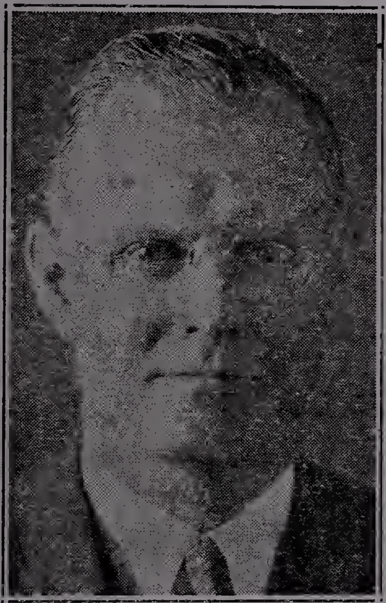

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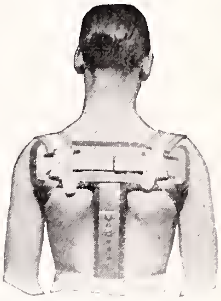

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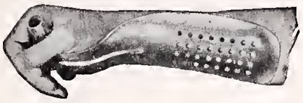

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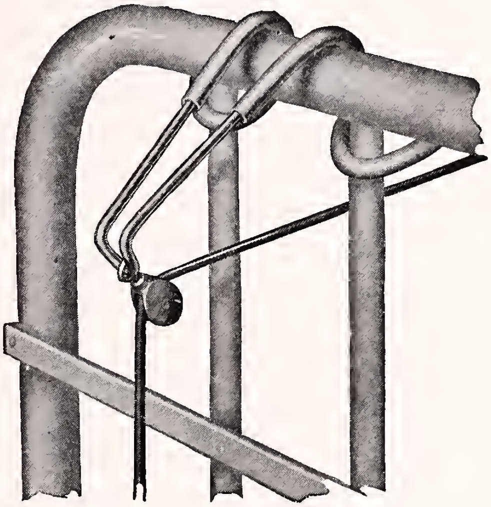

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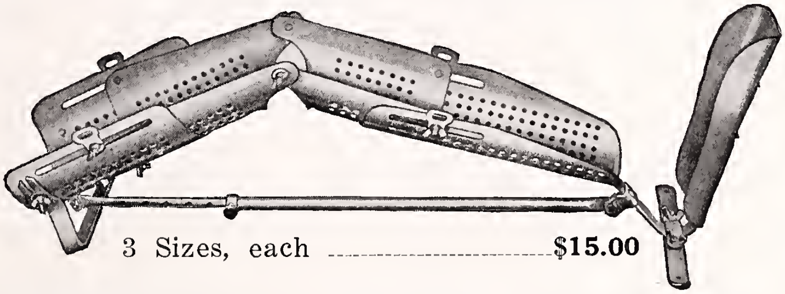

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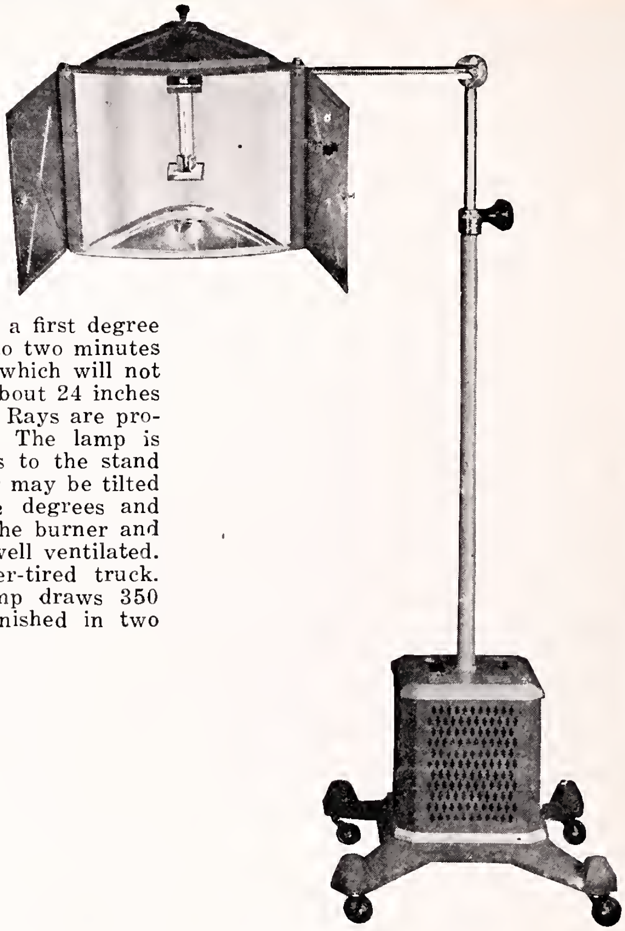

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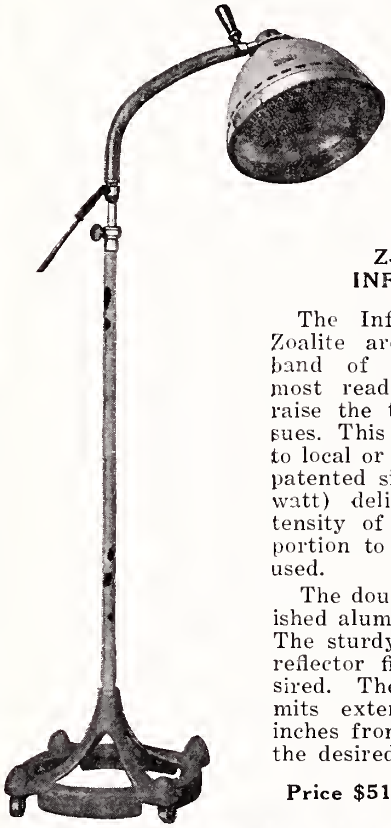

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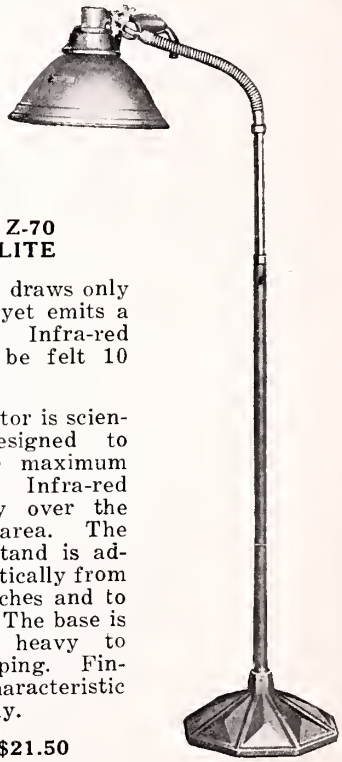

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Heretofore you have been warned to keep away from the stock exchange, but this year you have been driven to it. You have got to swap your practice for stock or go down.

Medical knowledge that was one time entirely in the hands of the specialist is now common knowledge and can not be charged for as before.

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It is not at all practical to think of a four year medical course at Ole Miss, nor would it be if the school was located in Jackson. The two year course is just what we need and what we can have.

We were very sorry that Dr. E. C. Ellett was unable to attend the meeting at Ole Miss.

There is no one thing common or of minor importance in the practice of medicine.

You will note that this issue of The Mississippi Doctor carries some unusually fine papers. This journal selects many of its papers. It brings subjects to you that you need to know about and by men who are amply able to give you the best that is known in this field. We are very greatful to Drs. Hill, Moore, and Rischener for their papers in this issue.

The Mississippi State Medical will meet in Jackson again next year. Dr. Will J. Mayo is expected on the surgical section.

Medical schools need to put in a special course for the general practitioner who must to a certain degree become a specialist.

Dr. Bethea's symposium on chest examinations before the "good will" meeting at Ole Miss was unique, practical, un-canny and calculated to be of great value in accurate of diagnosis of chest conditions.

The Editor of The Mississippi Doctor appreciates very much an invitation to attend the annual meeting of the Walnut Log Medical Society up at Union City on Nov. 13 and 14 of November. We are very sorry we will be unable to attend. This is a big affair the boys have up there. They have a fine medical program and then duck hunting et al. We just kinder dare them to invite us again.

Our next meeting of The North East Mississippi 13 County Medical Society will be held in Tupelo in December. We are expecting one of the best we have had for a long while.

A big part of the current medical education can and should be brought to the practitioner right at home.

Down at the Southern Medical you may have a chance to see and hear the great and profound Dr. Rudolph Matas. For years past and years to come the spirit of Tulane Medical School was and will be the spirit of this great medical philosopher. In the beginning he was born with a master mind. He had unusual opportunities by his affiliation with this great school. No other living man in our opinion possesses so much medical knowledge. He loves medical truths and by passing them on unselfishly, he seems to have been given many portions. In every field of knowledge he is a specialist. His brain is big and of the finest fiber. He has a medical soul that is magnanimous. His heart overflows with kindness and with sympathy for his patients. It will be a great treat to see him and to set at his feet and listen to his wisdom if only for one hour.

Take a little time to see Tulane while in New Orleans. It is a great school. Dean Bass is a man of vision. He is the essence of thoroughness in any undertaking. He is the outstanding leader in practicalizing modern medicine.

The North East Mississippi Medical Society can point to the President of the Southern Medical Association with pride and admiration. He is one of our own faithful and devoted members. He will do honor to this great medical association as its president.

If the profession carries modern medicine to the masses at a reasonable cost we need not fear State medicine.

The way to keep away from state medicine is for the profession to give such good service that the people will have no desire for it. This can be done by means of the well equipped clinic and the well equipped hospital in the small town out in the midst of the masses. Don't forget this.

Everything else being equal put up at the hotel when in New Orleans or Jackson or Memphis or any where else that advertises in The Mississippi Doctor. It will not cost you any more and it will help to finance the journal. Thank you.

Our November issue is going out just about three thousand strong. Who said Mississippi could not put out a medical journal?

If you want to read a journal that publishes good papers all the time and discusses the practical medical problems of today subscribe for The Mississippi Doctor.........For a single copy, one fifty for one year, in clubs of five, one dollar per year.

The good will get together meeting at Ole Miss in honor of Dean P. L. Mull and the two year medical school was a big success. It was good to the last act. In attendance it ranked well with the average state meeting. The scientific papers were good. Our welcome by Chancellor Powers was most cordial. The earnest blessings invoked by Mr. Guest were most fervent. The songs by Mrs. Martin were full of thrill and inspiration. The response to the welcome address by president-elect Acker was pointed and well said. The scientific symposiums by Drs. Livermore, Bethea, Street, and Rischener were the last word of reliable information on the subject. Dean Hyman of the University Medical School of Tennessee, brought an inspiring message of faith and good will. Dean Mull spoke touchingly from an earnest, a faithful, and an appreciative heart. Dr. Underword read encouragingly of the progress of medicine and quieted the fears of many on the matter of state medicine. State President Culley paid a high and a deserved tribute to the faithful work of Dean Mull, Dr. B. S. Guyton, and Dean Hyman et al for the medical department at Ole Miss in time of need. Yes, it was a nice big day. Surely it indicated to Dean Mull that the medical profession of the entire northern half of Mississippi appreciates his efforts, his faithful and untiring services for this school. Surely he must now know that the profession of the state is behind the medical department. It intends for this two year school to live and go forward.

The two year medical school at Ole Miss should live and should continue to function. We do not think we should consider a four year medical school, but the two year course has stood the test of time, the test of examination, and the test of practical application of modern medicine. Its thorough course challenges the admiration of the rich and the most highly cultured and its moderate fees make it possible for the young man of moderate means, but who has in reality a professional mind, a medical soul and a missionary heart, to come and to drink from the fountain of the latest and the purest medical knowledge. The two year medical school at Ole Miss hath wrought well. Our hearts swell with pride at her past record. We are bouyant with hope of her continued service. We need the teachings in physiology, chemistry, and bacteriology that it may bring to us. We trust that the medical profession shall determine that from this day on the medical school at Ole Miss shall have the benefit of practical application that we may be able to give and the yearly handshake of cordiality and good will that we may be able to bring to the Dean and to the student body. The gates of the spoils system in politics must not prevail against this school. Here Dean Mull, is our hand of good will, our heart of appreciation, and our blessings of hope and good cheer.

The Southern Medical Association meets in New Orleans on Nov. 18, 19, and 20. Dr. Felix J. Underwood, our own fellow member, our own efficient public health administrator, is president. We should attend this meeting for our own good, our own professional edification, and also to show our appreciation to the Association for bestowing this, its greatest honor on one of our number. We have been reliably informed that an unusually good program has been arranged for this meeting And in addition you will enjoy your stay in New Orleans. It is our greatest southern city perhaps when everything is considered. It is broadminded. It is cosmopolitan. It is rich in culture and refinement. It is most interesting for its past history. It is exuberant with future hope. New Orleans is charged with a medical atmosphere that will do the soul and the intellect of any practitioner a world of good. New Orleans is the home of the best medical school in the United States in our opinion. It has as its dean Dr. C. C. Bass, a native Mississippian, who knows how to apply modern medicine in a practical way, knows how to teach it so it can be applied. You can't afford to miss the Southern Medical Association.

We were muchly delighted to have Dr. R. M. Holder of Memphis down to the meeting at Ole Miss. He is one of the faithful and true. He stands steadfast and goes forward in the profession. He is a surgical philosopher and his heart overflows with human interest.

IN KENTUCKY

A young lady without much knowledge of literature was told that she should secure a book for her vacation trip. She asked a book dealer for a suggestion of what she might choose, and he recommended "The Kentucky Cardinal" by James Allen.

"No," said the young lady. "I do not believe I would care for such a book; I never was interested in ecclesiastical history."

"But you are mistaken about this book," said the bookseller, "this cardinal was a bird."

"Well that still doesn't interest me," said the young lady, "I do not care anything about his private life."—Clyde Kelly.

MUSIC HATH POWER

Young people seated in the parlor. They had the jazz orchestra habit. The cook in the kitchen dropped a pan full of dishes with a terrible crash. "Shall we dance?" asked the young man, politely.

WHERE HIS FAMILY CAME FROM

A party of tourists were discussing the Darwinian theory. One of them turning to the guide said, "And what, my friend, do you think of the matter?",

"Well, sir," said the guide, "You gentlemen may all have come from apes. It's not for me to contradict you. But, as for me, I can say that my folks came from Wales."—Rev. Anthony H. Evans.

Disabilities of the Spine

BY HENRY G. HILL, M.D.
Memphis, Tenn.

In attempting to discuss a subject of such magnitude it is impossible to do more than briefly outline a few of the most common lesions. Disabilities of the spine may result from trauma, disease or congenital defect. Its bony substance is subject to the same type injury and disease that might befall any of the skeletal system, and fortunately is just as capable of repair. Unfortunately however, many of these conditions are associated with damage to the cord, which when once destroyed makes no effort to regenerate.

TRAUMA—Perhaps the most frequent traumatic condition other than sprains and lacerations of muscles and ligaments is the compression fracture of the body of the vertebra. This may occur at any level, and usually results from indirect violence. Simple compression fractures of the cervical vertebrae are relatively rare, the most common location being in the lower dorsal and upper lumbar region. The symptoms vary widely depending upon its severity. Pain is constant and may be both local and referred. In severe cases with considerable destruction of the body a sharp angular kyphos is seen at the site of fracture. Involve-

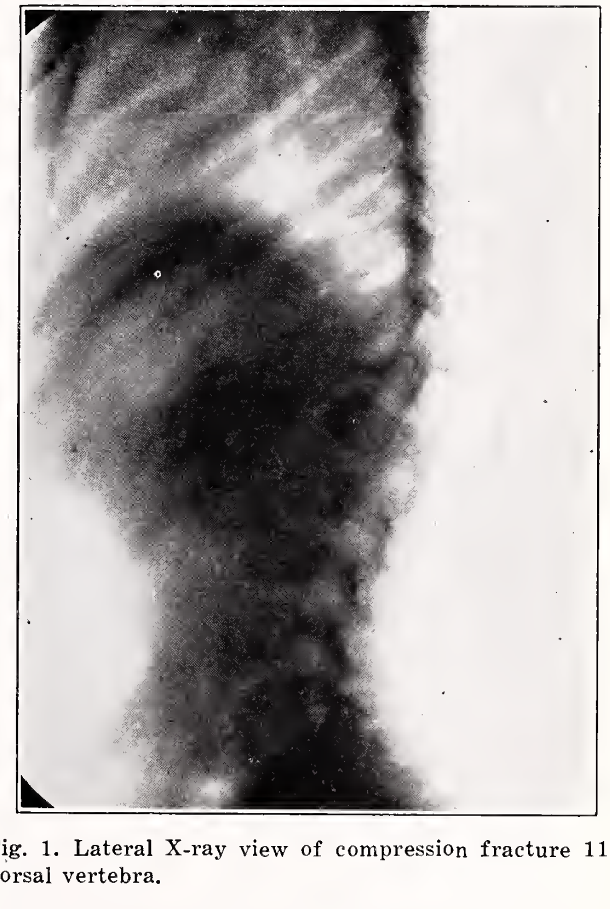

Fig. 1. Lateral X-ray view of compression fracture 11th dorsal vertebra.

ment of the cord is frequently associated with these injuries, and may result in any degree of paralysis.

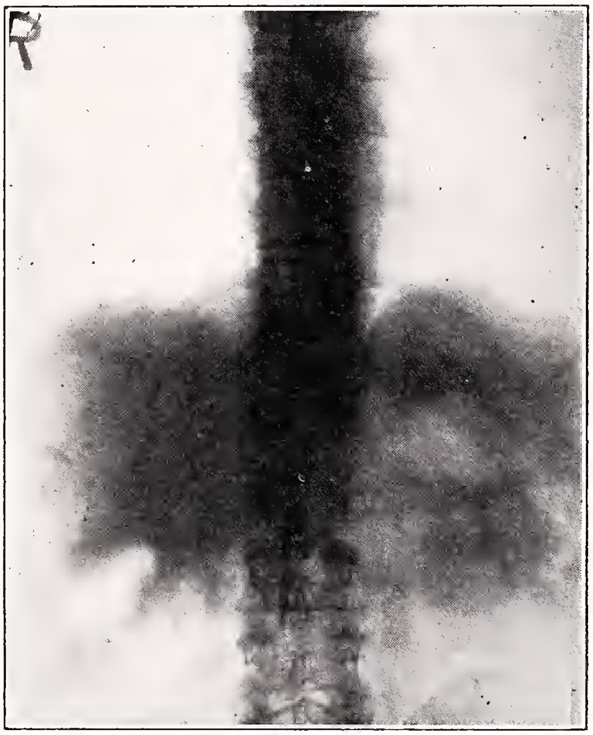

Fig. 2. Bone graft fusion 11th, 12th, dorsal. 1st, 2nd, and 3rd lumbar vertebrae for old compression fracture 1st lumbar vertebra (Kummel's disease).

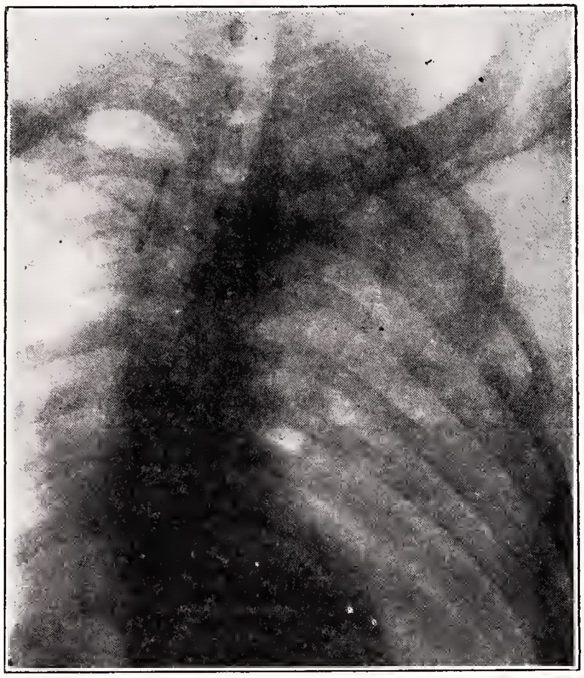

Fig. 3. Fracture dislocation of spine at level of 6th dorsal vertebra.

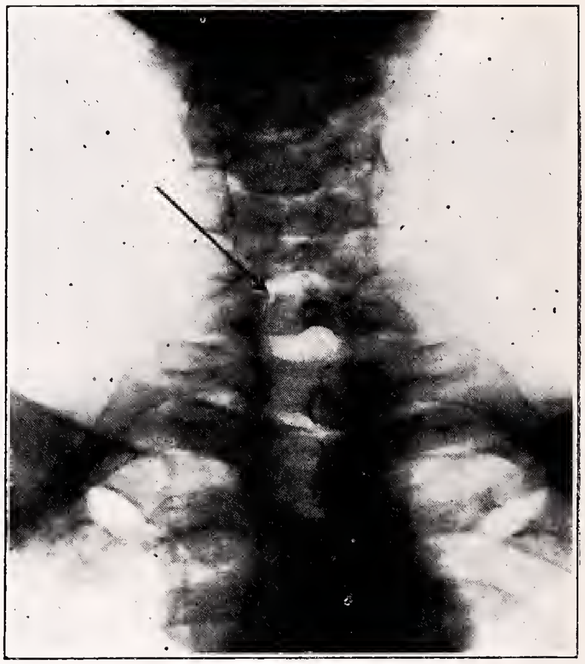

Fig. 4. Linea fracture body 7th cervical. Note arrow pointing to small nitch just to left of mid line.

The X-ray examination is by far the most important aid to diagnosis. In some cases little is to be learned from the anterio-posterior view and a lateral exposure should be made routine in all X-ray examination of the spine. In the lateral view the body of the injured vertebra is found to be decreased in height, especially at its anterior margin, so that it will present a wedge shaped appearance. There is an angulation of the spine at the site of fracture, and a decrease in the thickness of the inter-vertebral disc. A disturbance of the architecture of the injured vertebra is also seen in a well detailed picture.

The prognosis as to life does not depend upon the bony injury but upon associated conditions, especially lesions of the cord. Permanent paralysis will result from an acutal severance of the cord. Pressure from the bony fragments, oedema, and hemorrhage in the spinal canal may produce a paralysis that will disappear when the pressure is relieved. With no involvement of the cord the period of disability varies from six to twenty-four months. A permanent feeling of weakness frequently results when these injuries do not receive treatment.

Another type of fracture of the spine seen frequently in mechanics, football players, iron workers and trainsmen, usually a result of direct violence, such as a kick in the back or an injury sustained by falling on a small hard object, is a fracture of one or more of the transverse processes. Pain, tenderness and limitation of motion are the prominent symptoms and the fractured processes can be seen on the anterio-posterior X-ray plate. Such injuries are sometimes very troublesome and are frequently associated with extensive soft tissue injury.

Traumatic dislocations of the vertebrae are accompanied by severe symptoms and are always serious injuries. The cord is always injured, the prognosis is poor, the patient often dies before the examination can be completed. A certain amount of permanent disability invariably results.

The lamina are also sometimes fractured with or without fracture of the body of a vertebra. Fractures of the sacrum are rather rare and usually unrecognized unless a well detailed X-ray picture is obtained.

Fractures of the coccyx occur more often and

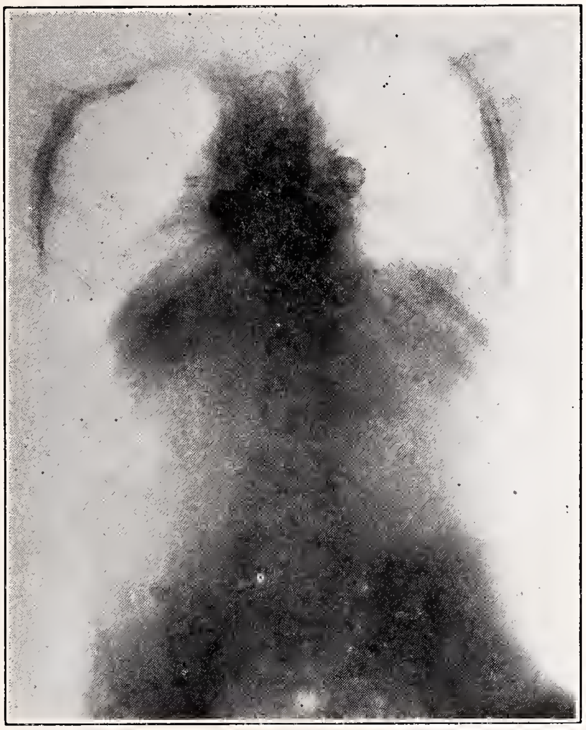

Fig. 5. Anterio-posterior view of advanced tuberculosis of spine involving several vertebrae mid-dorsal region.

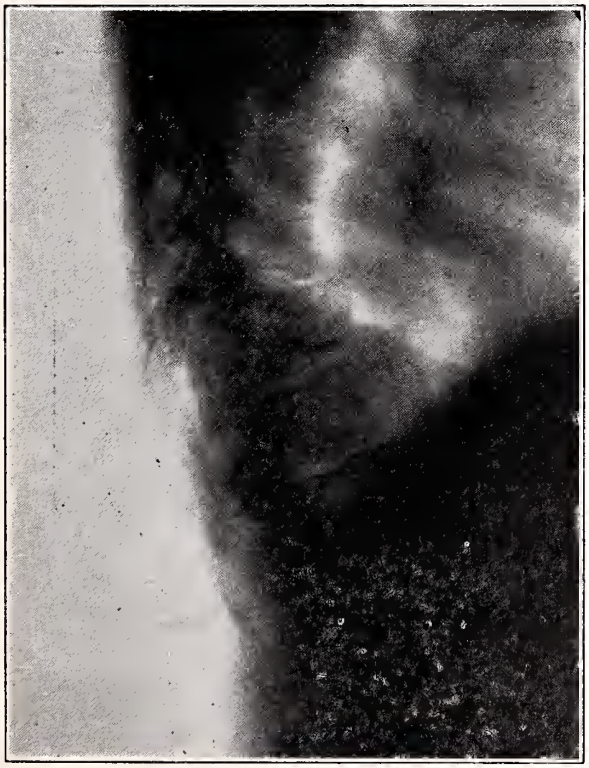

Fig. 6. Tuberculous destruction of the 10th, and 11th dorsal vertebrae.

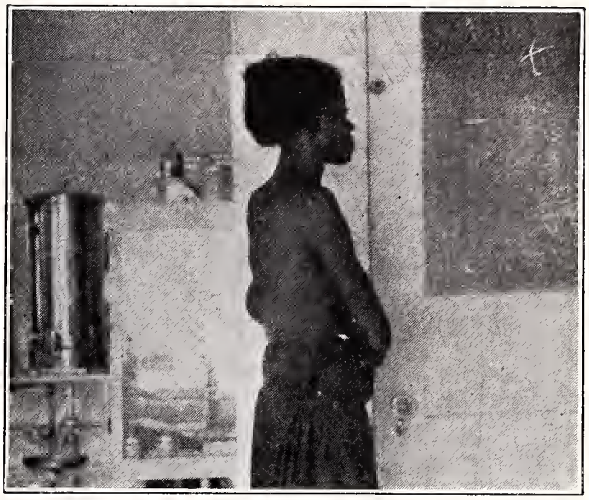

Fig. 7. Photograph of patient with tuberculosis of upper lumbar spine showing sharp angular kyphosis.

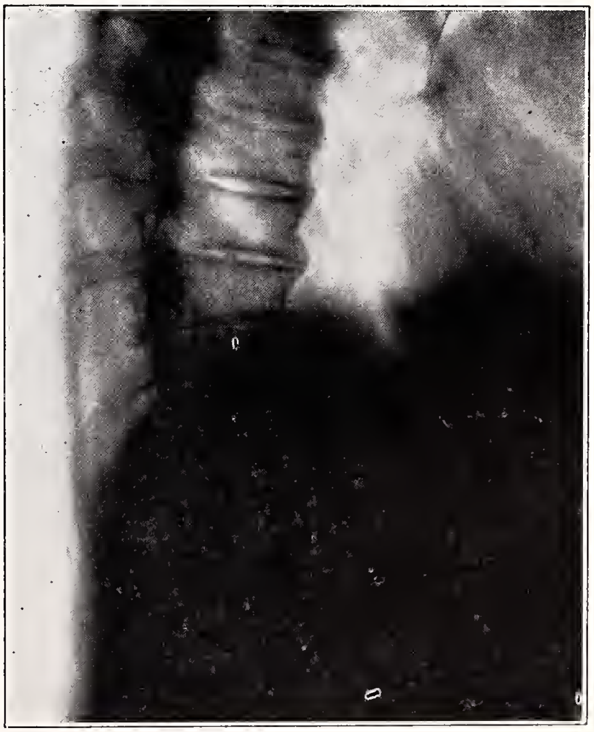

Fig. 8. Advanced osteoarthritis of dorsal spine with complete bony ankylosis of all dorsal vertebrae.

may be detected by palpation and manipulation of the coccyx with a finger in the rectum. Here too, the X-ray examination confirms the diagnosis.

Gunshot wounds of the spine are not uncommon, and cord symptoms even though indicating that the missile has entered the canal does not always mean an irremediable cord lesion. The question of when to do a laminectomy in these cases as in dislocations and fractures is often a difficult problem and must be decided by the surgeon in charge. When the symptoms indicate an incomplete lesion of the cord operative interference should be done within the first

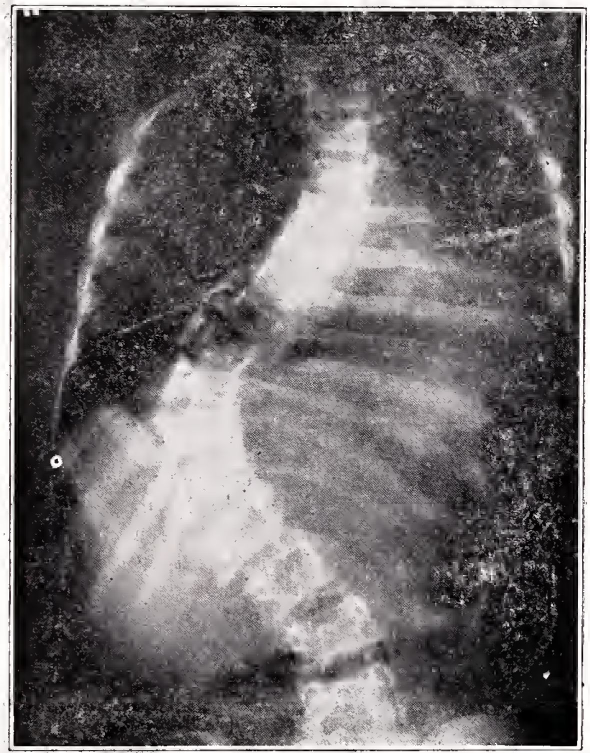

Fig. 9. Severe scoliosis following a neglected case of anterior poliomyelitis.

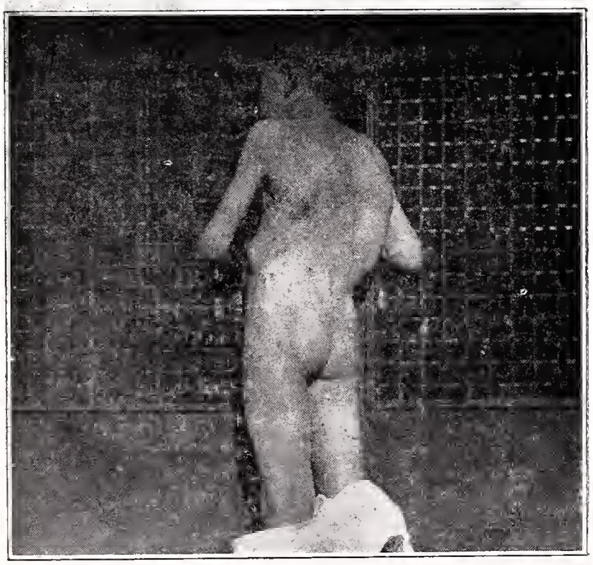

Fig. 10. Photograph of patient shown in Fig. 9.

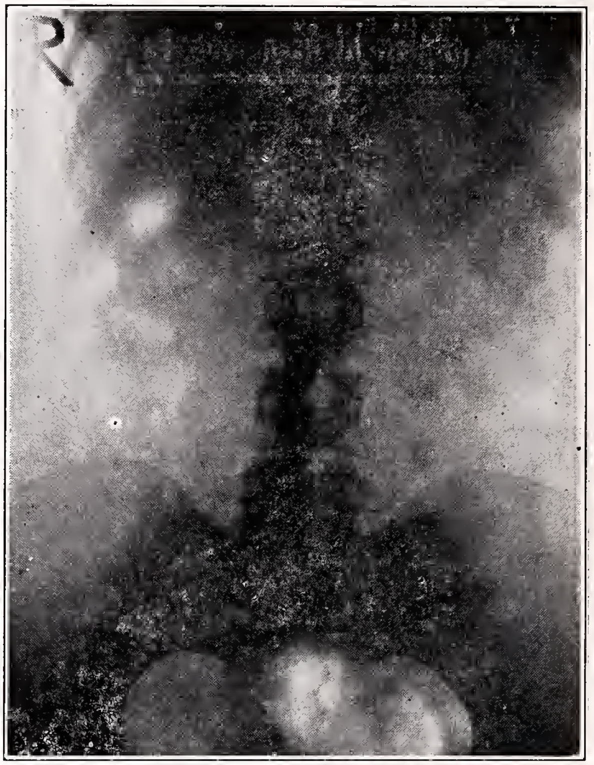

Fig. 11. Anterio-posterior X-ray view of scoliosis after bone graft to 4th and 5th lumbar vertebrae and sacrum; and fusion of left sacro iliac joint.

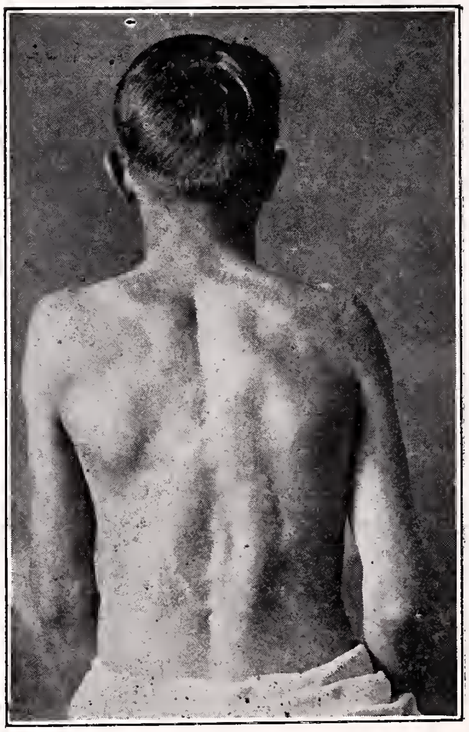

Fig. 12. Photograph of patient after bone graft operation for correction of moderate paralytic scoliosis.

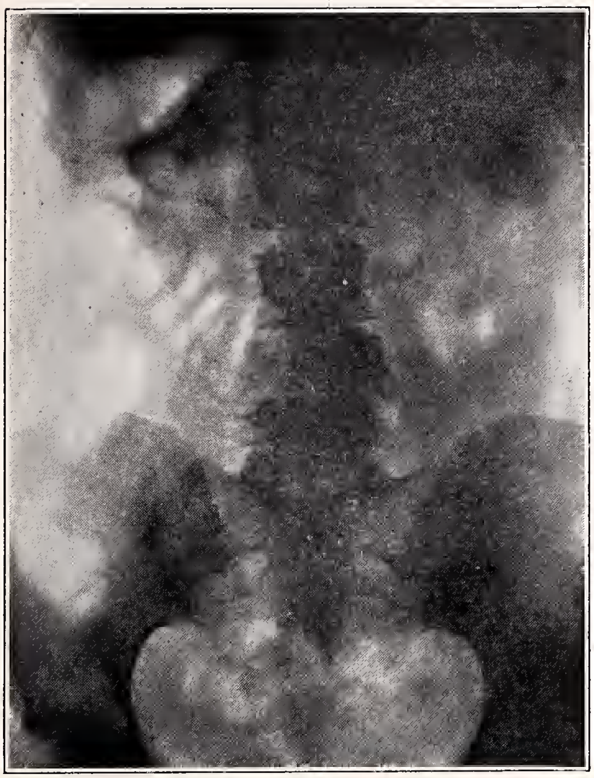

Fig. 13. Metastatic carcinoma destroying the body of 4th lumbar vertebra.

few days.

DISEASE—Tuberculosis of the spine or Pott's disease is a chronic destruction of the bodies of the vertebrae; it is seen at all ages but more common in children and may become acute at any state of the disease.

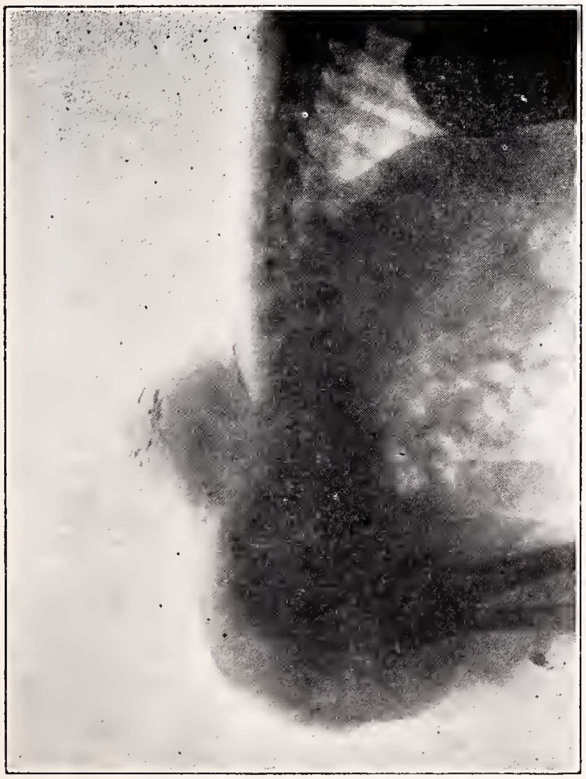

Fig. 14. Lateral X-ray view of lumbo-sacral spina-bifida.

The etiology of tuberculosis of the spine does not differ from that of tuberculosis of any location; it is an infectious disease, the tubercle bacillus being the causative agent The predisposing cause may be both general and local. Unhygienic living conditions, improper food, lack of sunshine and fresh air and other conditions that would lower the vitality of the patient would render them more suceptible to the disease, while trauma to the vertebra lowers its resistance and offers a fertile field for development of the bacilli.

The process may begin either in the anterior or central portion of the body, most often there are several minute foci gradually enlarging un-

Fig. 15. Photograph of patient with lumbo-sacral spina-bifida.

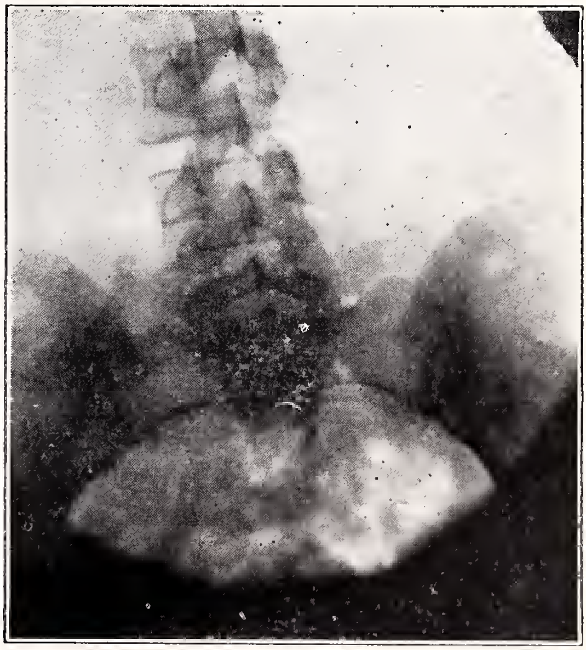

Fig. 16. Enlarged transverse process of 5th lumbar vertebra impinging upon wing of ilium.

til they coalesce, forming a cavity filled with tuberculous granulation enclosed by a cortical substance. Finally the vertebral bodies collapse under the pressure of the super-incumbent weight. The process is usually limited to one or two vertebrae but may extend up or down the spine including several. The inter vertebral discs though offering some resistance to the spread of the disease are quickly destroyed when the bone on either side of it is infected. The posterior portion of the vertebra is rarely involved.

Pain is an important symptom; it does not localize itself in the neighborhood of the disease, but is referred down the course of the nerves which lie in contact with the diseased vertebra. It is not always constant but is aggravated by jars or by sudden unguarded movements. In an effort to avoid these unguarded motions the muscles surrounding the diseased area of the spine are in a state of constant spasm. This is partly voluntary and partly involuntary but it always present and therefore an important symptom of Pott's disease. This spasm is indicated by a stiffness of the spine and an awkardness of practically all voluntary motions. The muscles relax when the patient sleeps allowing motion in the affected segment of the spine causing pain. This is responsible for the night cries so characteristic in children. Deformities appear as the destructive process progresses. This may be a sharp angular kyphos or a gradual rounded posterior protrusion of the spine, depending upon the number

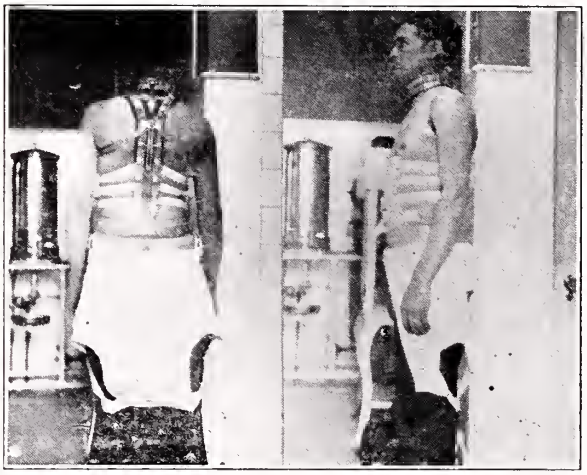

Fig. 17. Photograph of patient wearing Taylor Spine Brace with collar attached. Spondylitis upper dorsal vertebrae.

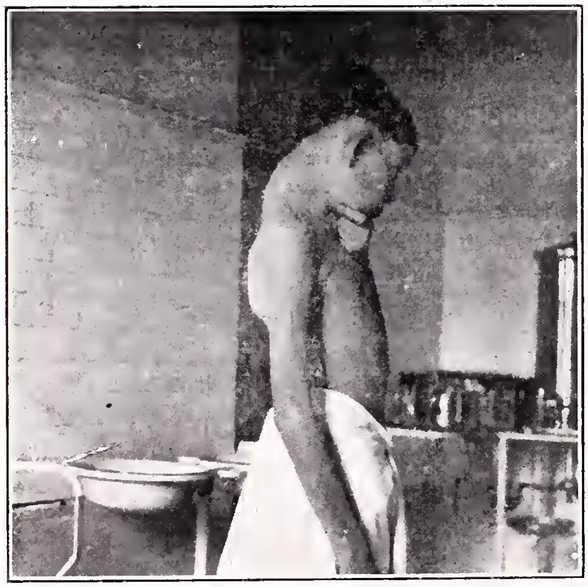

Fig. 18. Photograph of patient with osteomyelitis of cervical spine, involving 2nd, 3rd, 4th, 5th and 6th vertebrae before treatment.

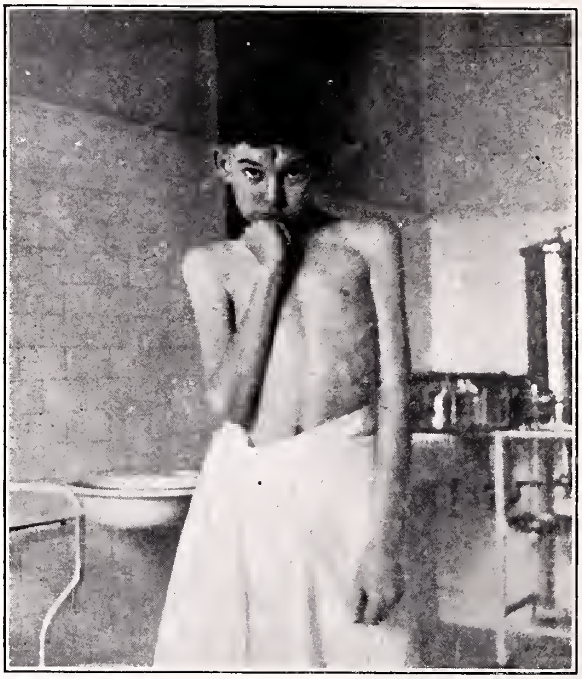

Fig. 19. Same as Fig. 18. Front view before treatment.

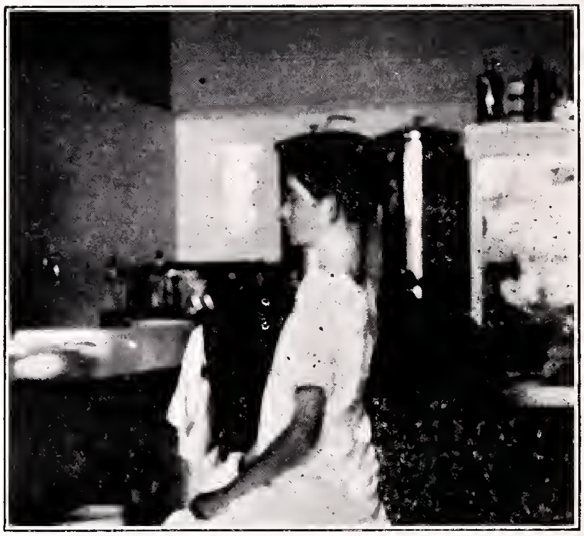

Fig. 20. Same as Fig 18 and Fig. 19. After treatment.

of vertebrae involved. In certain locations other deformities are seen such as the so-called "pigeon chest" where the disease is located in the thoracic region, the attitude of wry-neck frequently associated with tuberculosis of the cervical spine, etc.

The X-ray examination is very important in confirming a diagnosis. Evidence of the disease may be seen in both the anterio-posterior and lateral views, but it can be detected much earlier in the lateral. Irregularity of the anterior edge of the vertebra is characteristic, later wedging of one or two bodies and disappearance of the inter-vertebral disc is seen.

The prognosis depends largely on the age of the patient and the severity of the deformity. In the typical hunch back the contents of the abdomen and chest are compressed, the blood vessels distorted, respiration is difficult and there is considerable hypertrophy of the heart. Most of these patients die in the early years of life. When the deformity is less severe the outlook is more favorable. The prognosis in children is better than in adults, although many cases of both classes recover sufficiently to live useful lives when the proper treatment is instituted.

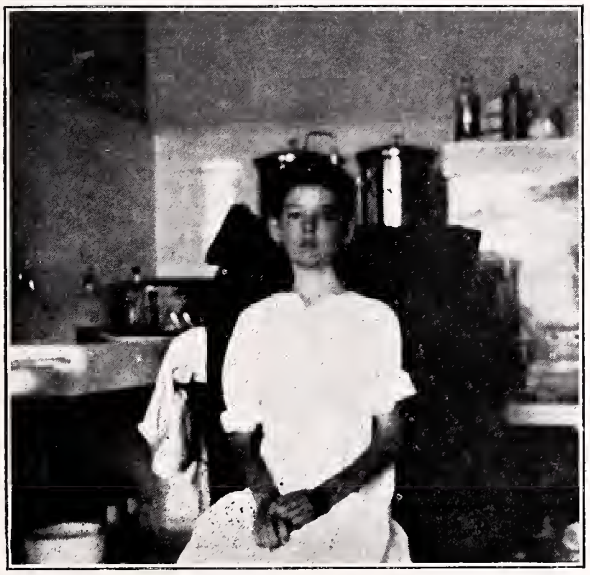

Fig 21. Front view after treatment.

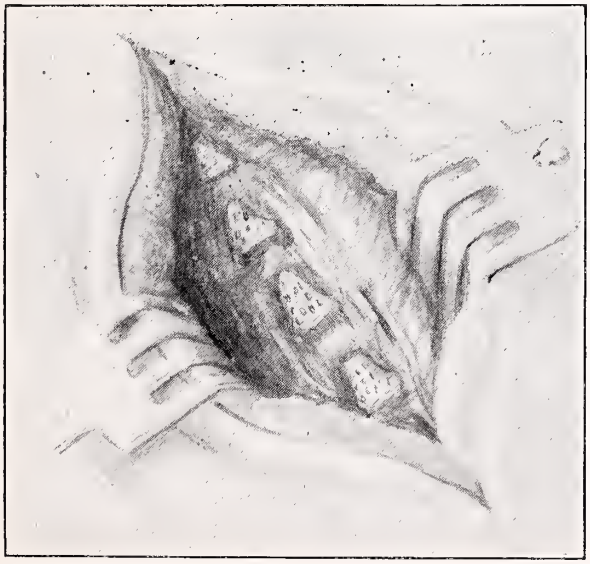

Fig. 22. (Pen and Ink drawing by Mrs. Hill). Spinous processes have been removed down to laminae. Skin, fascia and muscles retracted.

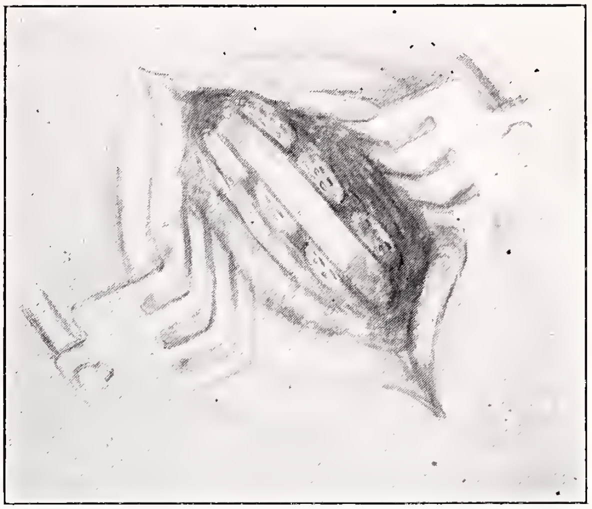

Fig. 23. (Pen and Ink drawing by Mrs. Hill). Laminae are removed exposing cord and its covering.

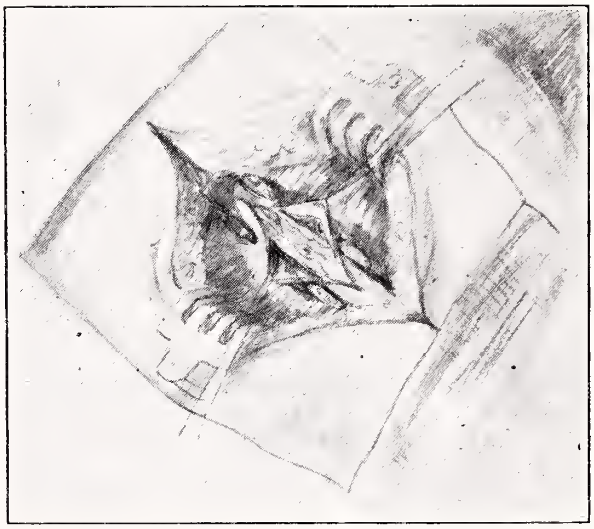

Fig. 24. (Pen and Ink drawing by Mrs. Hill). Coverings of the cord are incised and suture is passed through dura and retracted to expose cord substance.

Arthritis, or osteoarthritis, of the spine is a chronic inflammation affecting primarily the ligaments and the peri-osteal coverings of the spine. It is an ossifying peri-ostitis which binds the vertebrae firmly to one another. It is usually acute in onset, followed by a gradually increasing stiffness of the spine, it is associated with pain, weakness, stiffness and frequently the spine is bent into a long kyphosis. Its progress is very gradual often extending over a period of years, many cases proceed to complete bony fusion of the spine, and since the pain is due to motion the patient becomes pain free when ankylosis has taken place.

Occasionally acute osteomyelitis of the spine is seen. The bodies of the vertebra are usually involved. The symptoms are similar to those of any acute infectious process. It is sudden in onset, associated with a marked elevation of temperature, general disability, and the appearance of being acutely ill. There is an increase in the cell count, and other evidence of sepsis is present. Locally the disease area is attended with a deep boring pain, and is tender to deep pressure.

The prognosis is always grave but the more localized and chronic form is far less dangerous. Occasionally an abscess may be the first sign of the disease.

Anterior poliomyelitis is a disease of the anterior portion of the spinal cord—it may be followed by a complete or partial paralysis of one or more groups of muscles in any location in the body. Should this paralysis affect the muscles on one side of the vertebral column leaving those on the opposite side unopposed, the strong group of muscles will continue to exert their force gradually pulling the vertebra away from the mid line producing sometimes a very crippling scoliosis.

Syphilis, malignancy, etc., may attack the spine, these conditions especially the former, sometimes so closely imitate other diseases that a diagnosis may be difficult, upon physical examination; however, other evidences of the disease will be found.

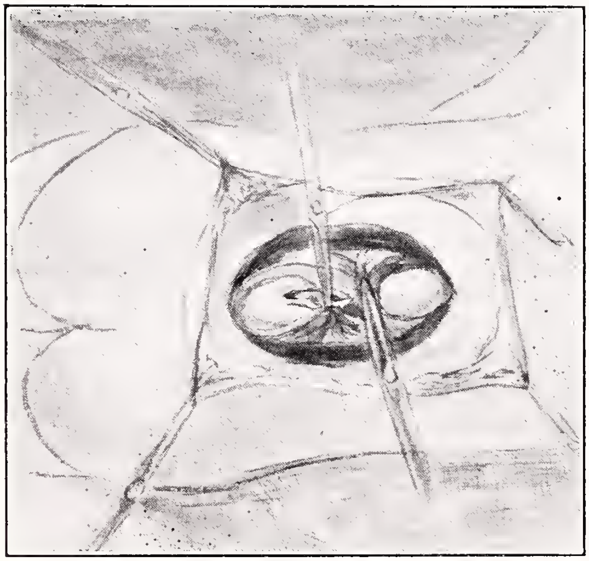

Fig. 25. (Pen and ink drawing by Mrs. Hill). Plastic operation for spina-bifida after sac has been removed.

CONGENITAL DEFECTS—Among the most distressing congenital defects of the spine is spina-bifida. In this condition the laminae or spine of one or more vertebrae are deficient, most frequently in the lumbo-sacral region allowing a protrusion of the contents of the spinal canal in the median line. In case the laminae are ununited but there is no protrusion the condition is called spina-bifida occulta. There are three distinct varieties of spina-bifida. First, the meningocele which is a simple protrusion of the arachnoid distended with fluid so as to form one continuous cavity; second, the meningomyelocele which contains cord substance in addition to the arachnoid, and third, the syringomyelocele, a protrusion of the cord. There is a great distension of the central canal, the sac wall being formed of the thinned cord and the spinal membranes.

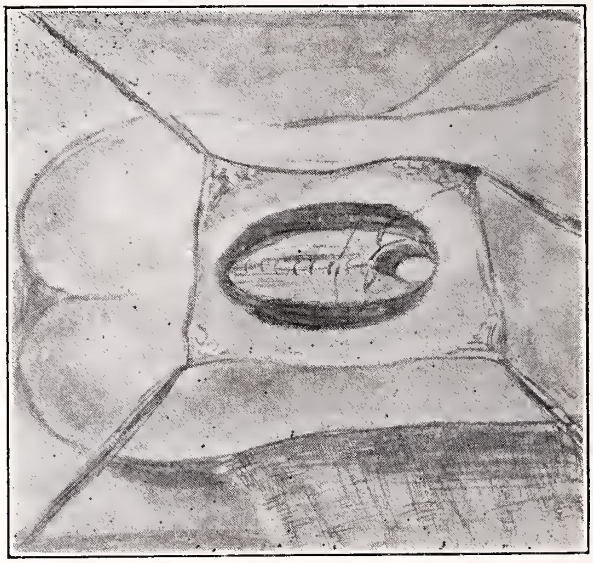

Fig. 26. (Pen and ink drawing by Mrs. Hill). Approximation of fascial flaps to meningeal defect.

A spina-bifida may vary in size from one to fifteen cms or more in diameter, it grows rapidly during the early weeks of life, it may be sessile or pedunculated. Upon pressure the tumor may diminish in size and increase the tension of the anterior fontanel.

Super-numerary vertebrae, cervical ribs, elongated transverse processes and numerous other defects are sometimes found on X-ray examination. Where their growth produces pressure on the surrounding tissue they may cause distressing symptoms, most often however, they are discovered on X-ray examination made for other purposes.

Congenital curvatures, as well as, ricketic changes are frequently discovered in the spine. When mild, such deformities usually go unnoticed unless for some reason the physician's attention is directed to a special examination of the spine.

Is the Operation of Prostatectomy to Become Obsolete?

BY THOMAS D. MOORE, M.D.
The Polyclinic
Memphis, Tenn.

This startling question may well be asked in view of the progress made in recent years in the treatment of prostatic obstruction. Due to the ingenuity of Bottini, Freudenberg, Young, Braasch, Caulk, and others, the punch operation has been employed successfully for many years in those cases in which the obstruction was of the median lobe or median bar type. Until the present time, however, in instances of marked hypertrophy with large lateral lobe obstruction, nothing short of a prostatectomy, either perineal or suprapubic, has offered any real prospect of relief.

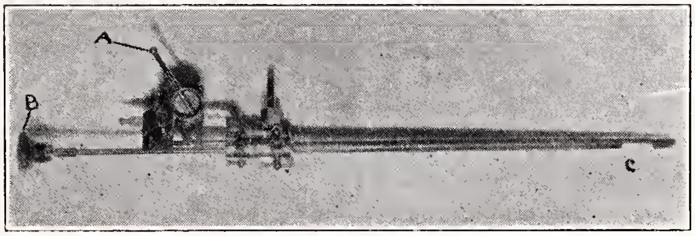

Fig. 1. The Stern-Davis Resectoscope. (A) Rack and pinion for operating loop electrode. (B) Observation telescope. (C) Fenestra which engages obstructing tissue.

In 1926 Stern devised the resectoscope, an instrument with which large lateral lobes could be removed, bit by bit, with a cutting current. In this instrument was incorporated a wire loop electrode which, by means of a rack and pinion was carried through the obstructing tissue with a backward and forward sliding motion. Each segment removed was cylindrical in shape, nearly an inch in length, and somewhat larger than the diameter of the cutting loop. Any number of such segments could be removed in as many tiers as was required to effect complete eradication of the obstruction. Unfortunately, the cutting current alone did not efficiently control hemorrhage, which often became profuse and uncontrollable. Chiefly for this reason, the use of the resectoscope was practically abandoned.

More recently, Davis has so modified and improved this instrument that the objections have been largely overcome. He devised a transformer, which supplies not only a cutting current, but also a coagulating current. (Fig. 2) By means of an automatic electromagnetic switch, operated by the foot, the coagulating current can be turned on at any time, making immediate coagulation available for controlling hemorrhage with the same electrode employed for cutting. Further, he devised a larger loop electrode with which larger segments of tissue can be taken, thus reducing appreciably the time of operation. (Fig. 3). He also shortened the beak of the instrument to permit its use in those cases of pronounced hypertrophy with a corresponding elongation of the prostatic urethra. In such cases, obstructing tissue must be removed for a distance corresponding to the diameter of the gland as measured from the vesical aspect to the verumontanum. The shortened beak renders this possible. No attempt is made to take the entire gland or all the adenomatous tissue. Sufficient obstructing prostate is removed, however, to provide a well open channel to afford complete relief from the obstructive symptoms.

In cases of this type, the importance and desirability of preparation or preoperative treatment is generally known. On examination, most of these patients have impaired renal function, often of an advanced degree, variable amounts of residual urine with an associated infection, very little cardiovascular reserve, and poor general condition. In former years, before the value of proper preparation was recognized, the mortality rate following prostatectomy was extremely high. One of the most notable advances in the field of urologic surgery, and one on which urologists should pride themselves, is the development of the several factors which have contributed to the reduction of the mortality rate. Chief among these measures of safety is an adequate period of preliminary treatment, the objects of which are: (1) to restore as far as possible normal renal function, as indicated by blood chemistry or phenolsulphonphthalein excretion; (2) to eradicate urinary infection; (3) to establish some degree of immunity to instrumentation in the urinary tract; (4) to build up cardiovascular reserve; and (5) to improve, as far as possible, the general condition of the patient. Other factors of equal importance, which have minimized the risk in these cases, are the use of local anesthesia and the effective control of hemorrhage. When these fundamental principles are observed, the mortality rate of prostatectomy should not exceed five per cent. In isolated series of cases a mortality of less than one per cent has been reported (Hunt and Young). These factors of safety are mentioned because they must be observed just as strictly in transurethral resection. When functional tests indicate approximately normal renal function, when there is little infection, and when no complicating pathologic process is associated, such as diverticula or vesical calculi, the resection of the prostate may be carried out after a very brief period of preparatory treatment. The need for preliminary suprapubic drainage is relatively infrequent. Occasionally, when renal insufficiency is marked, or when a period of several weeks or months of preoperative treatment must be carried out before a safe resection can be done, suprapubic drainage is preferable to continuous urethral catheter drainage. In two of the cases reported here this plan was followed.

It has been our custom to employ caudal and transsacral anesthesia. A preliminary hypnotic is desirable. We prefer sodium amytal, three to six grains, given rectally about one and one-half hours before operation. If the patient is over-apprehensive or nervous, a hypodermic of morphine also may be indicated.

The time of the operation varies in direct proportion to the size of the gland. When the gland is small and the obstruction is of the median lobe or median bar type, only a few minutes are required to resect the obstructing tissue and control the bleeding by coagulation On the other hand, when the gland is large and hypertrophy of the lateral lobes is great, much more tissue must be resected in order completely to relieve the obstruction and two to three hours may be necessary for the operation.

The tendency to hemorrhage is pronounced in cases in which the gland is large, and a longer time is required for its control. Meticulous care is essential in this part of the operation. Each bleeding point must be found and sealed by the coagulation current to avoid the annoying accumulation of clots, with resulting catheter obstruction following operation. When this has been accomplished, the irrigating fluid should return perfectly clear. In our experience, there has been no difficulty whatever with postoperative hemorrhage, which may be attributed to the care taken to control bleeding at the time of the operation.

Following resection a variable degree of local edema develops, which of itself may produce temporary obstruction. For this reason, an indwelling urethral catheter is fastened in and left in situ for two or three days. By that time, as a rule, the edema has subsided sufficiently to permit its removal. Then thin coagulum over the resected surface undergoes liquefaction necrosis, softens and separates by the tenth or twelfth day, leaving a clean, granulating area. The urine then may become blood tinged from the easily bleeding granulation tissue, and during the period of healing moderate urinary frequency may be expected. At the end of three or four weeks, however, the irritation almost entirely subsides, normal bladder function is restored, and there is no residual urine.

A logical question might be asked: With continued growth of the adenomatous tissue, might not an early recurrence of the obstruction be expected? In actual practice, the obstruction seldom, if ever, recurs. This is due, presumably, to a partial atrophy of the gland which so often follows relief of obstruction and the resulting congestion of the parts. A striking example of this is in the atrophy of the gland commonly observed in the interval be-

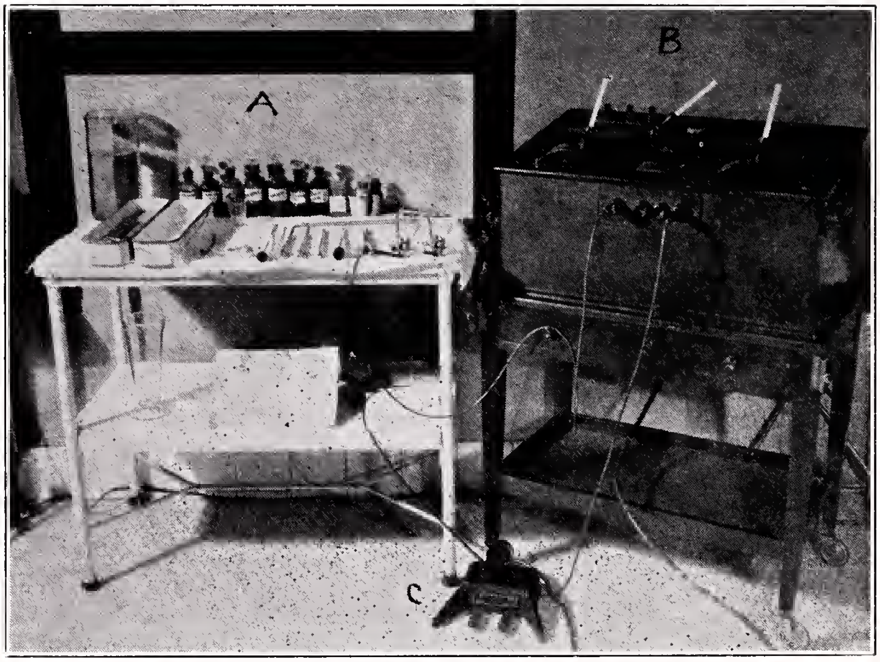

Fig. 2. Equipment employed in transurethral prostatic resection. (A) Table with sterile instruments. (B) Transformer which supplies the cutting and coagulating currents operated by foot switch, (C).

tween a suprapubic drainage and a second stage prostatectomy. Caulk has noted the same atrophic change following the punch operation, and his observations have been confirmed by Davis, who has noted this phenomenon repeatedly in cases in which the resectoscope was employed.

Davis has used this improved resectoscope in almost four hundred cases of prostatic obstruction, both benign and malignant, without a fatality and with no serious complications. Many of these resections were performed three or four years ago, so that sufficient time has elapsed to indicate the permanency of the beneficial effects. Such amazing results constitute irrefutable evidence of the desirability of relieving these elderly patients by this method, as it carries a negligible risk and encouraging prospects of permanent relief. Further, it must be stated that this procedure has passed the experimental stage and bids fair to render almost obsolete the major procedure of prostatectomy.

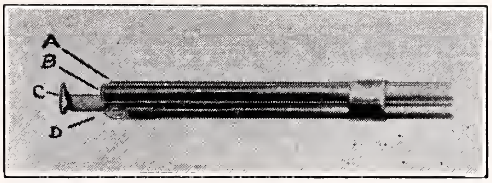

Fig. 3. Working unit of resectoscope. (A) Water conduit. (B) Observation telescope objective. (C) Loop electrode. (D) Incandescent lamp.

The following illustrative cases offer striking examples of the manifold advantages of transurethral prostatic resection over the time honored operation of prostatectomy. In each case it will be noted that the functional result was all that could be desired, and that the period of postoperative hospitalization was a matter of but a few days. When compared with the postoperative hospitalization following prostatectomy, which not uncommonly extends over a period of weeks or even months, the economic advantages alone of transurethral prostatic resection are obvious.

Case No. 37243, Mr. W. N. L., aged 82, was referred by Dr. C. R. Senter, of Byhalia, Miss., on account of urinary retention. The patient first experienced difficult micturition three years before. This had slowly and steadily progressed, and a year previously, due to his inability to pass the urine, it became necessary to use a catheter. Difficult urination continued, and six months later catheterization was again required. One week before his examination at the Clinic, acute retention recurred, and it was necessary to pass a catheter once daily. Approximately thirty ounces of urine was usually withdrawn. No urine was passed between catheterizations.

The patient's appetite was poor and he had lost fifteen pounds in weight during the past twelve months. On physical examination, a symmetrically enlarged, firm, smooth prostate, benign in type, was found. The gland was enlarged to a grade III on a basis of IV. The urine contained considerable microscopic blood and a moderate amount of pus. Renal function was normal, as indicated by a non-protein nitrogen of 34.4 mg. The leukocyte count was 13,150, with 74 per cent polymorphonuclear neutrophiles. The patient had a temperature of 101. A roentgen examination of the region of the urinary tract was reported negative. Because of his advanced age, the active urinary infection, and the presence of acute urinary retention, immediate suprapubic drainage under local anesthesia was advised and accepted.

Following the operation, the patient's temperature returned to normal within a few days, the incision about the tube healed by primary intention, and ten days later he was allowed to go home. Prior to his dismissal, a rubber urinal was adjusted to a receptacle for the urine draining from the suprapubic tube. He was advised to return after six weeks for transurethral prostatic resection.

Ten weeks later the patient returned. His general condition had greatly improved. The suprapubic tube had slipped out of the sinus three days before and could not be replaced. He was passing a small amount of urine with considerable effort per urethram; about fifty per cent of the urine output was passed from the suprapubic fistula. The nonprotein nitrogen of the blood was 38.7 mg., and the two-hour phenolsulphonphthalein output, divided into thirty minute periods, was as follows: (1) 14 per cent, (2) 34 per cent, (3) 18 per cent, (4) 7 per cent; total 73 per cent. An in-dwelling urethral catheter was fastened in place and the bladder was irrigated twice daily for three days. Following this treatment, the urine was practically clear.

Under caudal and transsacral anesthesia, a transurethral prostatic resection was performed at The Polyclinic. A grade III adenomatous hypertrophy of the lateral lobes and a small enlargement of the median lobe (grade I) were found. The median lobe was removed, then the left lateral lobe, and, finally, the right lateral lobe were resected as far as the verumontanum. The gland was very vascular and bled easily as the resection progressed, but all bleeding points were effectively controlled by the coagulation current. Approximately twelve grams of prostatic tissue was removed, (Fig. 4) and at the completion of the operation the channel at the vesical neck was wide open. A catheter was left in and the patient returned to the Baptist Memorial Hospital.

The postoperative reaction was light: the highest temperature, on the second day, was 100. The urine remained clear and three days following operation the catheter was removed. A measured amount of fluid injected into the bladder was passed without difficulty and with normal control. Five days following operation the patient was discharged from the hospital. One week later a letter from his home physician reported that he was in excellent condition, was up and about his farm, and had no urinary complaint except the necessity of passing the urine about every two hours, as the resected area had not yet had time to heal.

Case No. 37509, Mr. W. W. A., aged 72, was referred by Dr. N. G. Gholson, of Holly Springs, Miss. The patient complained of difficult urination, which he first noticed about ten years before. For a year or more the difficulty had been very pronounced and was associated with unusual frequency, both day and night, and the passage of small amounts of urine. He gave no history of acute retention and the use of a catheter had never been necessary.

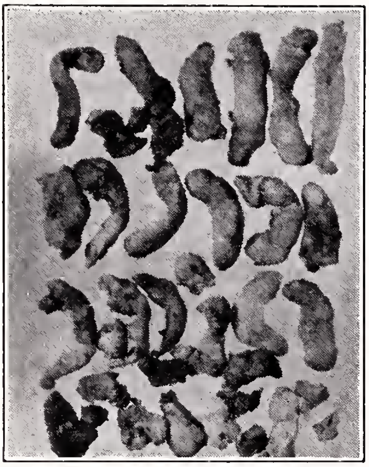

Fig. 4. Segments of prostatic tissue removed in case No. 37243.

Examination revealed a marked symmetrical enlargement of the prostate, firm in consistency and smooth in outline. There were four ounces of residual urine, which was grossly infected. The renal function was normal, as indicated by a nonprotein nitrogen of 30 mg. and a two-hour phenolsulphonphthalein excretion of 77 per cent, of which 43 per cent was excreted the first half hour and 16 per cent the second. The roentgen examination of the region of the urinary tract was negative. The cystogram was normal except for moderate elevation of the base.

The patient was placed in the hospital for preoperative treatment. A urethral catheter was fastened in place for continuous drainage and medication. He had several severe rigors with high fever, but with appropriate treatment this reaction subsided. After three weeks of preliminary care, his condition was considered satisfactory for resection of the prostate.

Under caudal and transsacral anesthesia at The Polyclinic, a moderately enlarged median lobe and a very pronounced lateral lobe obstruction were corrected by a transurethral prostatic resection. The slight bleeding was well controlled by the coagulating current. A catheter was left in and the patient returned to the Baptist Memorial Hospital.

After operation, the urine was blood tinged for twenty-four hours and was then clear. When the catheter was removed on the third day, it was found that he emptied the bladder completely and with normal control. On the fifth day particles of sloughing tissue appeared in the urine and the patient experienced increased difficulty of urinating, presumably due to the separation of the coagulated tissue in the vesical neck. The urethral catheter was replaced and left in until the tenth day. No further difficulty was experienced after the catheter was finally withdrawn, there was no residual urine, and the control was normal. The patient was discharged from the hospital twelve days following operation.

Case No. 26174, Mr. W. L. J., aged 79, was referred by Dr. N. E. Murphy, of Clarendon, Ark., because of acute urinary retention. The patient had undergone examination at the Polyclinic five years earlier. At that time he suffered from difficult urination and one and one-half ounces of residual urine had been found on cystoscopic examination, due to a moderate median lobe enlargement of the prostate. A punch operation had been advised and refused. The urinary difficulty had steadily and slowly progressed, and for one week before examination catheterization had been necessary two or three times daily. The size of the gland had materially increased since he was first seen. The nonprotein nitrogen of the blood was 46 mg. His urine was grosly infected; the leukocyte count was 14,650 and the polymorphonuclear neutrophiles 74 per cent. A urethral catheter was fastened in for continuous drainage and medication. The following day the patient developed pain in the epigastrium, associated with bloating and eructation of sour material. The pain was referred to the right scapular region. There was marked tenderness beneath the margin of the right costal arch. The leukocyte count had risen to 23,250. On the fourth day, although an ice bag had been kept over the region of the gall bladder, local tenderness was much more pronounced and the leukocyte count had reached 43,600. A diagnosis of empyema of the gall bladder was made and exploration advised.

Under spinal anesthesia a cholecystectomy was done by Dr. Robert L. Mason. The gall bladder was the size of a large pear, distended with purulent material, and there were numerous areas of gangrene varying in diameter from a few millimeters to one centimeter. After removal, drainage was established. At the same time a suprapubic cystostomy was performed because of the prostatic obstruction. The patient made an excellent recovery and was discharged from the hospital on the eighteenth day. A rubber urinal was adjusted to take care of the suprapubic drainage.

Two months later he returned for further consideration of the bladder obstruction. He had gained in a general way, his color was good, and he had no digestive complaint. He was wearing the suprapubic tube with a good deal of local discomfort. The urine was grossly infected. The renal function was normal, as evidenced by a nonprotein nitrogen on the blood of 30.7 mg. and a two-hour phenolsulphonphthalein excretion of 68 per cent. After a few days of treatment by bladder lavage, the urine was practically clear and he was considered in good condition for a transurethral resection.

The operation was performed at The Polyclinic under caudal and transsacral anesthesia. The suprapubic tube was clamped, in order to permit distention of the bladder. The median lobe was about the size of an English walnut and, in addition, a grade II lateral lobe obstruction was present. The median lobe was removed in its entirety, then both lateral lobes were resected; altogether, about ten grams of prostatic tissue was removed. (Fig. 5). Hemorrhage was slight and effectively controlled by coagulation. A catheter was fastened in the urethra and the patient returned to the Baptist Memorial Hospital.

The following morning the urine was clear and the suprapubic tube was removed. One week later the suprapubic fistula was closed. The catheter was therefore removed. Urination has since been normal, under normal control, and there has been no residual urine. A free stream is passed and, aside from a moderate frequency, the patient considers himself well. He was discharged from the hospital ten days following operation.

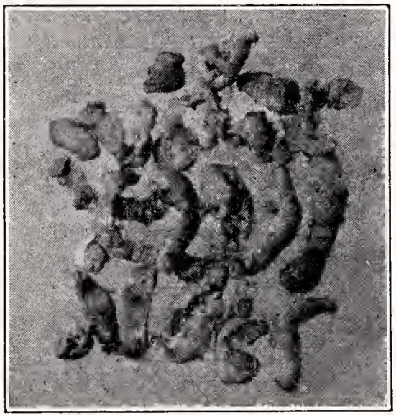

Fig. 5. Prostatic tissue removed in case No. 26174.

SUMMARY

The instrumental correction of prostatic obstruction may be said to be limited no longer to cases of median bar and median lobe obstruction.

By means of the Stern-Davis resectoscope, all types of prostatic obstruction, both benign and malignant, are amenable to transurethral resection.

When proper preliminary treatment has been carried out, the correction of prostatic obstruction by this method is attended with very slight risk. In a series of nearly four hundred cases operated on by Davis by this means, no fatality nor serious complications have occurred.

As compared with prostatectomy, the functional results are as satisfactory, the period of convalescence, is appreciably shortened, the average time being from five to seven days, the hazard is far less, and the beneficial results may be expected to be permanent.

Some Practical Points On The Eye

By Dr. RISCHNER
Memphis, Tenn.

Question of glasses in children. Necessary in myopes and squints. Not often necessary for other symptoms, such as headache, blinking, tiring, etc. These usually depend on other causes and frequently pass off without special attention to the eyes. Children sometimes invent complaints due to a desire to wear glasses. If glasses are necessary for these conditions they are usually only temporary.

Squint or crossed eyes. Very important to treat such cases soon after the trouble develops. The first thing is glasses, and these can be worn before the end of the second year. Supplementary treatment is possible and often helpful, but as a rule unless the condition is benefitted in a few weeks it will never be benefitted by anything but operation. Tendency to operate early. As early as the fourth or fifth year. Many operations, but the simple "clipping of a muscle" very rarely is sufficient, and several operations are often necessary. A good cosmetic result can usually be secured, but a good functional result is the exception.

MYOPIA—High myopia is usually congenital and occurs in high degree. The acquired form develops in previously normal eyes about the ninth to twelfth years, tends to increase for seven or eight years, and is apparently self limited as to the amount. These cases can be helped by glasses, not only as to vision but as to progress. Difficult problem in girls to get them to wear the glasses. Endocrine influences considered in treatment by adrenalin drops, for which excellent results are claimed. Requires yearly or oftener tests, possibly changes of glasses and refraction if near work. Sometimes advisable to take a child out of school. Difficult to restrict near work because we use the eyes in eating, all indoor life, even sitting talking to people who sit close to us.

GLAUCOMA—Is one of the most important and serious diseases of the eye, and especially because it is so common. The acute form is attended with such violent inflammatory symptoms and sudden loss of vision that it demands attention, and the only thing to say about it is to emphasize the necessity of early treatment. If let run on for ten days or two weeks the damage is permanent. Most cases require operation.

The chronic form is insidious and often overlooked, mistaken for cataract and ascribed to trouble with glasses. Calls for careful examination of all eyes when the need for reading glasses is felt. Most cases show failure of vision only, and often the central vision remains good, so that only expert examination will detect the trouble at a time when something can be done. Hard to generalize as to treatment as each case has to be considered on its merits. Treatment only arrests and prevents progress, does not restore, so something must be done while vision is still good.

CATARACT—The main thing to say about cataract is that not necessary to wait till it is "ripe" and vision is p. l. only. Now considered proper to operate when the visual needs of the individual can no longer be met. Many cases operated when the eye ground can still be seen. If this fact can be made known people with glaucoma will no longer wait till the eye goes out before seeking relief, thinking they have cataract.

While we may say that we have no cure for cataract except operation, it seems something can be done by glasses, hygiene and attention to the general health to arrest the progress or make the individual more comfortable.

SECOND SIGHT—Is the development of nearsightedness in middle aged and elderly people and means beginning cataract. Ability to read without glasses in the sixties, having previously needed them, is no cause for congratulation.

CEREBRAL CONSIDERATIONS — Cushing said that the commonest symptoms of which patients coming to his service at the Peter Bent Bregham hospital complained, was impairment of vision. Since that statement was published we have more often referred patients with optic nerve disturbance to neural surgeons, with rather astonishing results. Many times the eye symptoms are the first symptoms of central nervous troubles such as tumor, multiple sclerosis and other conditions.

MEDICAL CONDITIONS—The same is very often true of Bright's disease and to some extent of arteriosclerosis. Astonishing how many C. V. R. cases have serious visual disturbances. Don't need eye treatment. Some improve. Many do not.

GOITRE—Aside from well known exophthalmos, too extensive surgery with damage to parathyroids often cause tetany and cataract The fact that this is accompanied by a calcium deficiency started investigations on this line as to the cause of cataract, but it has not brought out anything very definite. Certainly the production of calcium deficiency experimentally does not produce cataract, nor do people with cataract show a lowered blood calcium.

These cataracts present no special surgical problem except the youth of some of the patients. They can be successfully operated. Parathyroid feeding and restoring in calcium content in the blood has improved the vision and cleared the eyes of some cases.

A character, like a kettle, once mended, always wants mending.

In conversation, avoid the extremes of forwardness and reserve.—Cato.

Book Review

"Health Horizons" is a book which should not only be in every doctor's general library, but also incorporated in the curriculum of every high school student. This book would be a handsome addition, if not a necessity, to the home library, so practical is it for use from the kitchen to the drawing-room. Compiled by Miss Jean Broadhurst and Miss Marion Lerrigo, it is dedicated to the memory of Miss Emma Dolfinger, whose services to the country in child welfare work and research begun in the educational program in the schools of Louisville, Ky., have become a blessing of such wide scope we could not measure more than its beginning.

From the earliest theories of health and its relation to air, exercise, clothing sanitation, food, heredity and eugenics, many of them quaintly interesting or amusing, the authors trace tersely and accurately chapter by chapter the progress of the human race in recognizing health values. And our enlightenment of today appears very recent, indeed. From anthrax to yellow fever, the mother and teacher, have a reference for prevention and protection against communicable diseases; from asthma to scurvy, they have the causes of the non-communicable ones. Food and nutrition, a most important subject from infancy to maturity, is exploited clearly and well. Statistic of the amazing progress of medicine and science only intensify the value of this so thoroughly compiled little book, whose intrinsic value is enhanced by the utter readableness of its contents and the concise manner with which they are put together. Price $3.00

Mid-South Assembly for February

Dr. John F. Erdmann, New York, N. Y., Surgery; Dr. Harold O. Jones, Chicago, Ill., Gynecology; Dr. Irvin Abel, Louisville, Ky., Gynecology; Dr. John J. Moorhead, New York, N. Y., Surgery; Dr. Chevalier Jackson, Philadelphia, Pa., Laryngology; Dr. Ralph Pemberton, Philadelphia, Pa., Internal Med.; Dr. Paul D. White, Boston, Mass., Internal Med.; Dr. Ross McPherson, New York, N. Y., Obstetrics; Dr. Sanford Gifford, Chicago, Ill., Ophthalmology; Dr. J. C. Litzenberg, Minneapolis, Minn., Obstetrics; Dr. H. R. M. Landis, Philadelphia, Pa., Internal Med.; Dr. William R. Cubbins, Chicago, Illinois, Surgery; Dr. Vilray P. Blair, St. Louis, Mo., Plastic Surgery; Dr. Harry A. Fowler, Washington, D. C., Urology; Dr. Wilburt Davidson, Durham, N. C., Pediatrics; Dr. Chas. L. Scudder, Boston, Mass., (Fractures), Surgery; Dr. Kenneth M. Lynch, Charleston, S. C., Internal Med.; Dr. A. M. Barrett, Ann Arbor, Mich., Psychiatry; Dr. F. T. Lord, Boston, Mass., Internal Med.; Dr. Chas. A. Elliott, Chicago, Ill., Internal Med.; Dr. Martin H. Fischer, Cincinnati, Ohio, Internal Med.; Dr. Morris H. Fishbein, Chicago, Ill., After Dinner; Drs. Lord and Fischer will speak twice each.

This is to give you an idea in advance of what you have in store for you at the Mid-South Post Graduate Assembly which will meet in February at the Peabody Hotel in Memphis. There is no other medical association like it. Prepare and make ready to go. It will hold for four days. The Shelby County Medical Society is to entertain with a stag supper the first night. Fishbein is the after dinner speaker. This is enough said.

MEDICAL ORGANIZATIONS OLD AND NEW

The editor of the Journal of the American Medical Association' under the editorial caption "Medical Organizations Old and New" Page 932, Vol. 97, No. 13, September 26, 1931, takes occasion to criticise the existence of any and all medical organizations, old or new not under the direct control of the American Medical Association.

As the personnel of practically every medical organization is composed of members of the American Medical Association, and as practically every ethical medical man in the country is a member of some independent medical society, the editorial impresses one that it is the opinion of just one man.

The American Medical Association has done much to strengthen the position of general medicine throughout the country. That it could not represent general medicine and special medicine at the same time is amply proved by the existence of the American College of Surgeons, the American College of Physicians, the American Medical Editors' and Authors' Association had hundreds of other medical societies and associations devoting themselves to specialties and local conditions.

While, on the basis of national economy, the editor of the Journal of the American Medical Association advises physicians "to well consider whether or not money spent in supporting various organizations is providing adequate return" and in criticising all independent organizations, he makes statements relative to the American Medical Editors' and Authors' Association, that to be kind to him, are more critical than correct.

He states that the "Association has been appealing to physicians throughout the country to take membership." The Association has never issued a single invitation to anyone to become a member. As it has done in the past, it takes this present opportunity to extend to any contributor to medical knowledge, an invitation to make application for membership, and in doing so, to submit a list of his books or contributions.

That the Association has been selective and discriminating in electing applicants to membership may be appreciated when one considers that out of the thousands of medical contributors, less than fifteen per cent have been elected. The roster speaks for itself.

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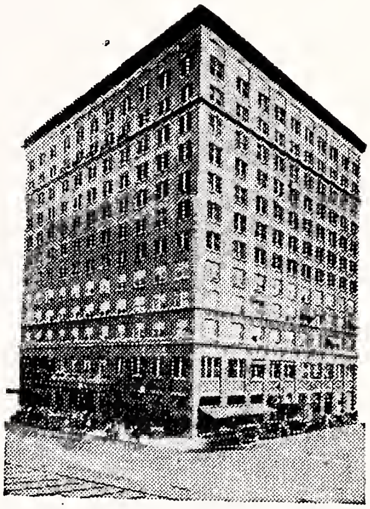

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The editor of the Journal of the American Medical Association implies that the American Medical Editors' and Authors' Association is a new organization. For his information, the Association began as the American Medical Editors' Association in 1869, and was founded by Dr. Nathan Davis, father of the American Medical Association. Following Dr. Nathan Davis in the office of president of the Association were such men as Theophilus Parvin, Horatio Wood, Henry O. Marcy, George M. Gould, Hobart Armory Hare, Charles E. de M. Sajous, Henry Waldo Coe, James Evelyn Pilcher, Walter Wyman, Thomas L. Stedman, Edgar A. Vander Veer, George M. Piersol, George W. Kosmak, Seale Harris and others whose names stand for honor, accomplishment and undying fame.

The editor of the Journal of the American Medical Association criticises the "Medical Mentor" as a periodical largely devoted to lucubrations on literary topics, et cetera. In this connection one can only regret that the editor did not first consult a standard dictionary before he used the word lucubrations if, as it evidently was, his intention to criticise.

One word more may be said in answer. The editor of the Journal of the American Medical Association in criticising independent medical organizations, sounds a word of warning when he says "members will always do well, however, to inform themselves as to the purposes for which money is collected, the manner of its expenditure, et cetera. This word of warning is good and it is timely—and may be commended not only for independent medical organizations, but for City, County, State and National organizations.—Medical Mentor.

The American Medical Association is all right, fine enough, but hundreds of important subjects of interest to the profession go untouched by it. The Mid-South Medical Assembly is the best four day meeting in the United States. We did not ask the A. M. A. anything about it. We would not take one single honor from the A. M. A. nor the most brilliant editor, but there is plenty of room for the Medical Mentor. It has a fine work to perform.

Ambition is like electricity; useful when properly controlled, dangerous when uncontrolled.

Bad memory has its root in bad attention.

Reading maketh a full man, conference a ready man, and writing an exact man.—Bacon.

Only dead men never change their minds.

On earth there is nothing great but man;
In man there is nothing great but mind.
—William Hamilton.

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"Waiter."

"Yes, Sir."

"What's this?"

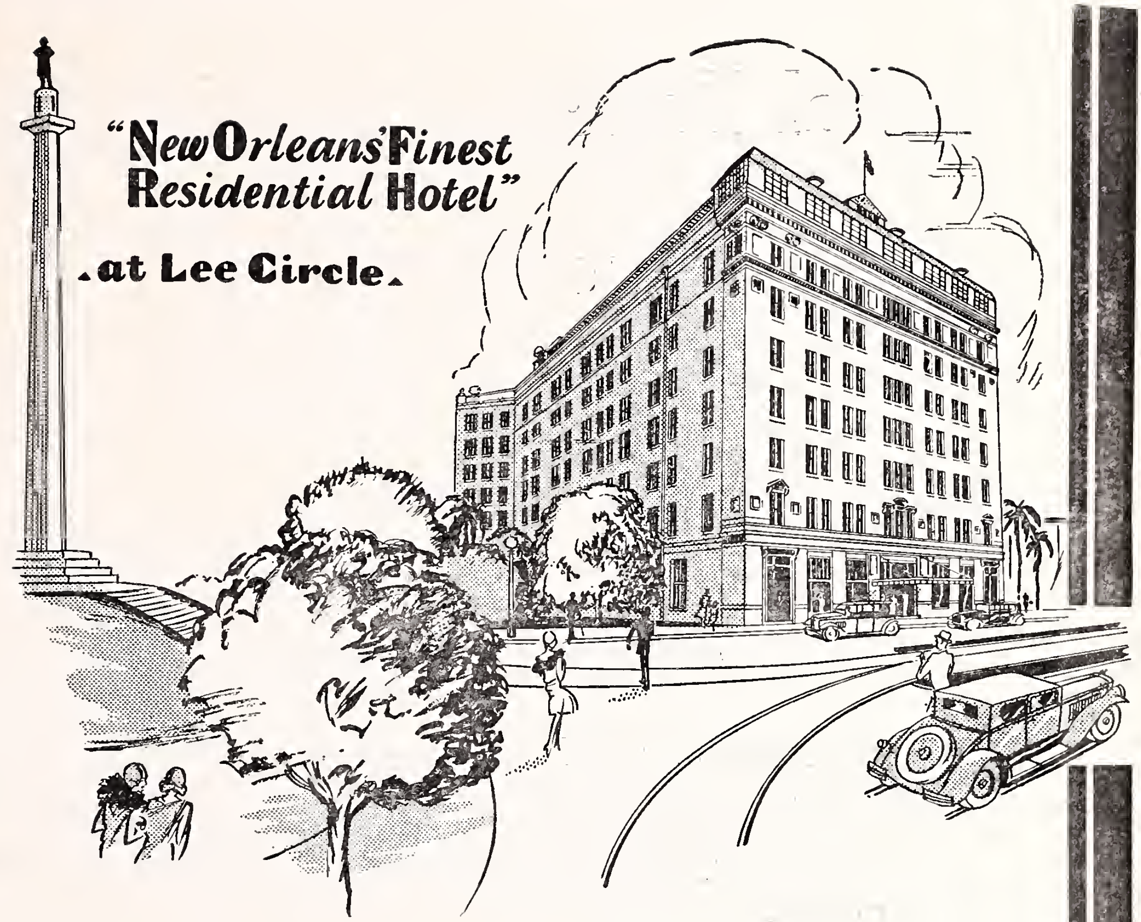
"It's bean soup, sir."

"I don't care what is has been; the question is, what is it now?"

NEVER BEEN TRIED TWICE

She: "Why are you looking so thoughtful, my dear?"

He: "I was wondering how Jonah got away with it when his wife asked where he had been away from home all that time, and he told her a whale had swallowed him."—John N. Tillman.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Matt. 7:12.

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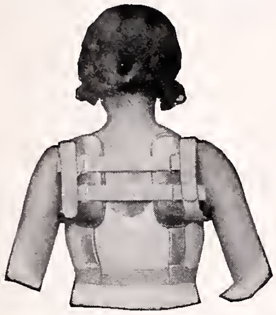

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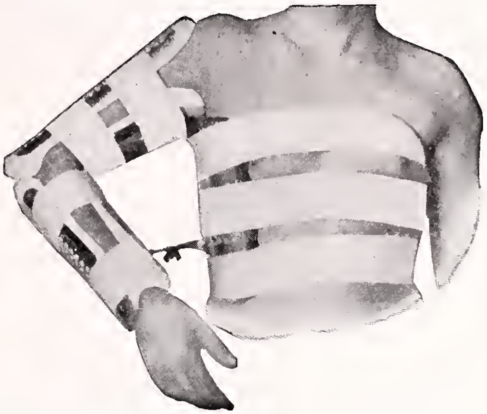

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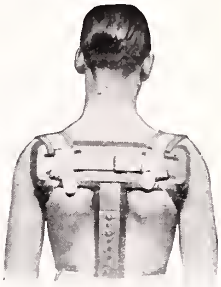

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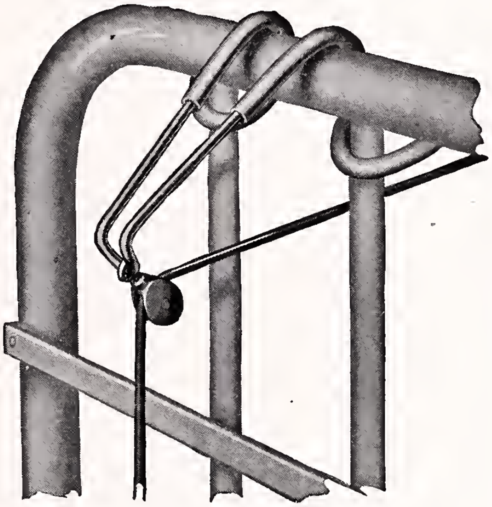

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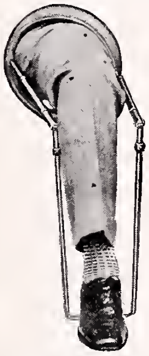

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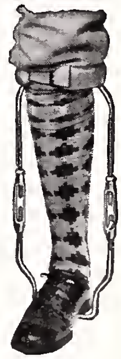

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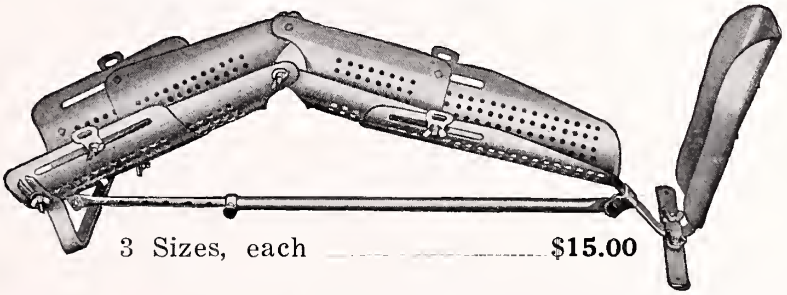

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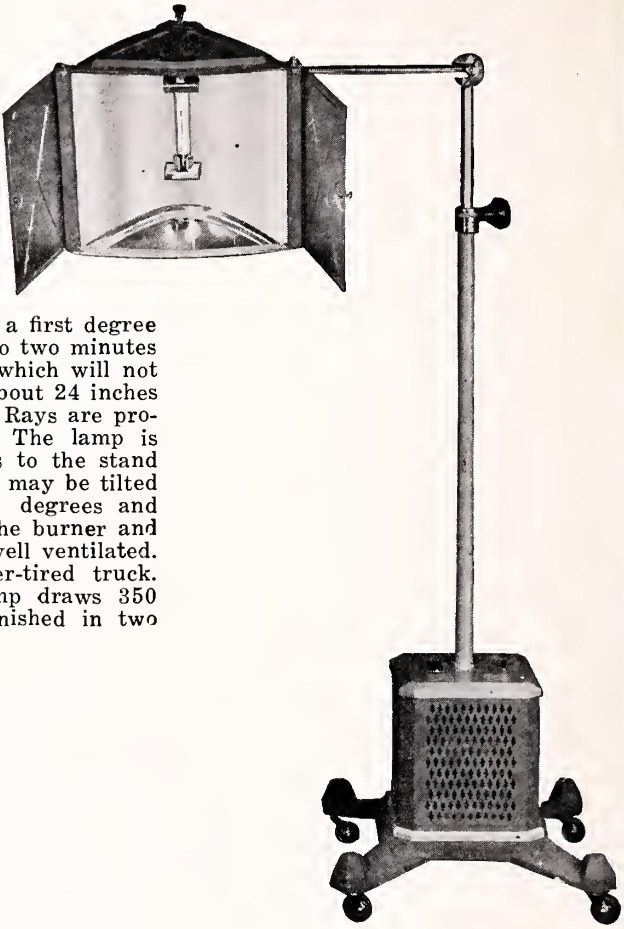

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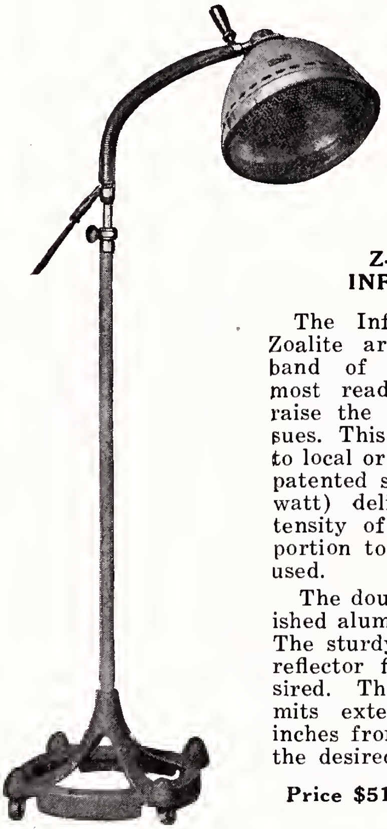

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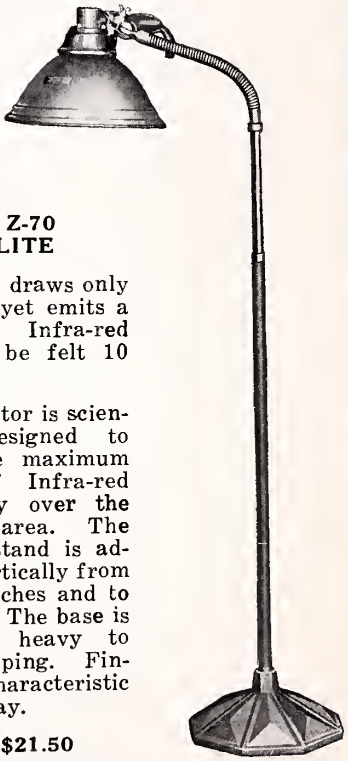

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—AND—
NORTH MISSISSIPPI 6-COUNTY MEDICAL SOCIETY

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Entered as second-class matter, January 18, 1926, at the post-office at Booneville, Miss., under the Act of March 3, 1879.

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You will read with interest and profit the paper by Dr. A. Street of Vicksburg on Peptic Ulcer. Dr. Street always gives you something worthwhile. He gives you the latest and the best on the subject. We are interested in the Street Bros. They had "their origin" in Northeast Mississippi.

The Southern Medical Association was quite a success considering the "times." New Orleans entertained most cordially as usual. Dr. Felix J. Underwood presided with grace and efficiency and his address was most able. The next meeting goes to Birmingham. This was a fine selection. Birmingham is a fine city. It is full of the spirit of Drs. Harris and Dabney and Mr. Lorenz. They will make the meeting a mighty big success. No doubt about that.

Why not send your friend The Mississippi Doctor for a Xmas gift, one fifty a year for single copy, in clubs of five one dollar. It is the journal with a mission. It publishes very select papers.

It would be a great step forward for medical efficiency and financially also, if the medical profession would invest in office supplies and equipment instead of taking so many chances on every get-rich-quick proposition that comes along.

We want to congratulate Tupelo and Dr. Acker on the fine program presented at the December meeting. It is fine to have men like Drs. Haggard and Collier. Dr. Haggard has been president of the American Medical Association. He is a matchless orator, is well versed in medicine and surgery and is a most magnetic personality.

Keep in mind the Mid-South Medical Assembly in February. It meets at the Peabody Hotel. It gives you more for less money and in less time than any other yet organized. Attending is believing. Go and be convinced.

We are glad to publish a paper by Dr. S. C. Barrow of Shreveport, La. President of the State Association on "Medical Economics"., at the request of some of our subscribers in that commonwealth. It is very interesting and offers food for thought. It deals with state medicine and related problems. Some of the doctor's statements sound a bit strong, yet they have the ring of veracity. Where charity hospitals abound it is pretty sure that many will receive aid that do not really deserve it. On the other hand in medical school centers like New Orleans, Public health departments over step some times. Papers like Dr. Barrow's help us to define the lines more definitely and stay within them. We appreciate his paper. You will enjoy it.

You will read with interest the paper in this issue by Dr. Felix J. Underwood on "Our Medical Problems". He offers as a prophylatic to "state medicine", conservative public health work. He backs this statement up with mighty good reason. This is a paper that you should read and study and consider well. It rests with the medical profession as to whether we will have state medicine. We must give the people such good service that there will be no demand for it. The profession and public health should march hand in hand. They will when they understand. The profession must broaden and extend its service to the public. It must invest in Clinics and hospitals and must do more preventive practice. It is not within the realm of any public health department to do all the preventive work in medicine and surgery. You should file Dr. Underword's paper away for future reference. It is ably written and gives you much valuable information.

A balanced financial system will be the first order of the day for the new legislature. A tax system that will be certain to bring in enough taxes to operate our government and to press as lightly as possible on all and to be as just as can be made to each one who enjoys the protection of our government, is the question.

The removal of our colleges from the "spoils system" as nearly as possible, hard surfaced roads for the main trunk lines, and public schools are the big problems before our "new law makers." Our public health department should be operated as economically as possible, but it should not be crippled if it can possibly be avoided. It will not be good economy. The question of charity funds for the small hospitals of the state will be one of the most important pieces of legislation to be enacted. The small hospital was left in the cold the last four years. The man out at the cross roads and down by the mill who has paid taxes all these years was not considered when he was sick. The hope of this nation, medically speaking, is the well ordered clinic and the small hospital. Our state charity hospitals have no doubt served well in their day, but they are not reaching the people, just a few near by. It is not practical to carry patients two hundred miles to a charity hospital, not even a hundred. We are not making any fight on the state owned hospitals. But we believe that the medical profession, the churches and philanthropy should build and equip the hospitals and that the state should pay for the actual charity that comes to them. We do not believe in encouraging charity. We do not believe in state medicine. The community hospital will help to keep us away from state medicine. It will multiply the efficiency of the medical profession. It will be our greatest means in bringing about an equal distribution of physicians and surgeons. It will bring modern medical service to the people, to the masses, rather than carry them to it. For the state to pay for the charity in the small hospital without investing in hospitals will be a nice piece of economy and at the same time it will do justice to the country folks who have paid taxes all these years and who have not had what was coming to them. A distribution of funds to the small hospital is good economy for the state and good economy for the people. Under this system the entire state can be quite well taken care of for the amount that is now expended on the five state charity hospitals,and it will do away with a multitude of politics. Every man will have his own physician at home, or very near home. If we can keep our splendid state charity hospitals and help the small ones over the state all good and well. Charity needs to be decreased. The distribution to the small hospitals will help to do this. But just a few big charity hospitals over the state will not serve the people now. We have out grown that day. The people up on Yellow Rabbit and down on Vinegar Bend must be considered. Justice must be done. Fairness must be meted out. Economy must be practised. Modern medicine and surgery, preventive and curative, must be delivered to the masses. Where education has been carried, modern medicine can go. More medical service for less money is what a distribution of charity funds to the small hospitals will mean.—The Booneville Independent.

Financial Statement

Financial Statement of The Northeast Mississippi 13 County Medical Society as of Dec. 4, 1931.

Receipts 145 members	$870.00
Refund from defunct Commercial Banking & Trust Company	39.20
Total Receipts 1931	$909.20
Expenditures—	
T. M. Dye State Secretary 145 members	$580.00
Mississippi Doctor 145 subscriptions	145.00
Stationery	50.18
Telegrams and telephone calls	7.12
Stenographic work	5.00
Refund for over paid dues Dr. Hamrick	1.00
Printing programs for the year, with the exception of December meeting	58.85
Total expenditures	$847.15
Balance in bank as of Dec. 4, 1931	$62.05

A doctor was called in to attend an ailing baby.

"You'll have to give him a dose of castor oil," said the medical man to the child's mother.

The mother, one of the ultra-modern type, had expected the prescription to take the form of a violet-ray bath or something like that.

"But, doctor," she said, "castor oil! Castor oil is such an old-fashioned remedy."

The doctor nodded in agreement.

"Babies, madam," he replied, "are old-fashioned things."

Peptic Ulcer*

BY A. STREET M.D.
Vicksburg, Miss.

When mentioning peptic ulcer we think of ulcer located in the duodenum or stomach. However, in a few cases peptic ulcer may and does occur at other points in the gastro-intestinal tract, notably in the lower oesophagus and in the anomaly of the small gut known as Meckel's diverticulum. When such an ulcer occurs at these unusual sites it is probably associated with the presence of areas of ectopically placed gastric mucosa which give rise to acid secretion and maintains the ulceration. These ulcers may give rise to puzzling symptoms, may bleed freely and may perforate. They do not occur often, but it is well to remember that they do occur, especially when dealing with cases of unexplained gastro-intestinal tract hemorrhage.

The incidence of duodenal and gastric ulcer is high. It is conservatively estimated from autopsy and clinical information that 10 per cent of the population of the United States have active or healed ulcers.

The cause is not definitely known. There is strong evidence that some of the following factors have a causative relation:

1. The erosive action of the acid gastric juice.
2. Interference with the normal duodenal reflux, depriving the mucosa of the pyloric region of the protective action of the alkaline duodenal content. Pylorospasm could act in this way.
3. Lowered resistance of areas of mucosa from interference with blood supply. This could result from embolism or thrombosis of small vessels, from ischaemic pressure of muscle spasm, and from spasm or endarteritis.
4. Trophic disturbance, originating from disorders of the vagus or sympathetic nerves.
5. Infection by pathogenic micro-organisms, either local infection or metastatic from focal infection in other parts of the body.

From a practical viewpoint I feel that the most important of these causative factors are the erosive action of the acid gastric content, muscle spasm, and infection.

Consideration of erosion of gastric content brings up the question of variations in composition of gastric juice caused by emotional, psychic, glandular, and dietary factors. Also there may be abnormal variations in the composition and amount of alkaline duodenal content. We know that gastric and duodenal ulcer are unusual in cases of achylia, and that high acid values are common when ulcer is present. Mann and Williamson and later other workers have produced ulcers in dogs exactly like those seen in men. They have produced ulcers that show characteristic chronicity, not usually present in other experimentally produced ulcers. The method is as follows: The animal's stomach is divided at the pylorus, and the duodenal stump closed. The jejunum is then divided close to the duodeno-jejunal junction and the proximal end anastomosed to the ileum. The distal end of the stomach is then anastomosed to the distal end of the jejunum. Thus the stomach and jejunum are entirely deprived of contact with duodenal contents. Nearly 100 per cent of dogs so treated developed typical ulcers and some of them died of hemorrhage or perforation. Then to test the effect of exposing these ulcers to the duodenal fluid, the abdomens of some of the dogs were reopened, the ulcers observed, the operation was taken down and normal anatomy re-established. Later examination showed the ulcers healed. This work seems to prove beyond doubt that erosive action of gastric puice which is not properly mixed with duodenal content is a factor in the cause of ulcer. Ulcers have been produced in animals by section of the vagus nerve, destruction of the celiac ganglion, or destruction of the splanchnic nerves. Also injections into the blood stream of powdered substances intended to produce sterile emboli have successfully produced ulcer. Experimental ulcers have been produced by injecting streptococci, particularly of certain strains, into the blood stream, as was shown by Rosenow and others. Ulcers so produced are not so typical as the ulcers produced by Mann. Saunders and his coworkers have recently presented strong evidence regarding infection as a causative factor of ulcer. They have consistently obtained a particular strain of streptococcus from all of their specimens of resected gastric and duodenal ulcers, and have identified the organism by cultural and agglutination methods. It is interesting to note that this organism would not grow in media containing small amounts of bile.

Bacteria are suspected of initiating ulcer in two ways: 1. By producing embolism or thrombosis of slender blood vessels. 2. By selective action of bacteria or bacterial toxins on the involved tissue.

Judd calls attention to two types of pathology observed in patients who present symptoms of duodenal ulcer: First, those who have localized ulcer, with destruction of one or more layers of the duodenal wall. Second, those with duodenitis, an extensive surface inflammation without destruction of the mucosa. Cases of the duodenitis type will usually respond to medical treatment. Gastritis, involving mostly the pyloric antrum, has also been observed (Konjetnrey. Orator, Kalima) at the time of both primary and secondary operations for ulcer.

Peptic ulcers are most often located near the pylorus, much more often in the duodenum than in the stomach, and usually in the first portion of the duodenum which is most exposed to the acid gastric content. The lesion may be single or multiple. Ulcer apparently begins as a superficial lesion of the mucosa, the simple acute ulcer. If it does not heal spontaneously or by treatment certain complications will probably develop. These are:

---

*Read before the joint meeting of the North Mississippi Medical Society and the Northeast Mississippi Thirteen County Medical Society, University, Mississippi, October 29, 1931.

1. Cicatrization, with deformity and varying degrees of obstruction.

2. Hemorrhage.

3. Perforation.

4. There is a possibility of malignant change developing in gastric ulcer, a change which is not likely in ulcer of the duodenum.

Ulcer occurs more often in men than in women. The symptoms have seasonal exacerbations. The characteristic symptoms are usually present. However, they are not always easy to gather from the patient's story. This was first impressed on me by finding ulcer in patients by roentgen ray examination or by laparotomy in whom the history had not suggested the presence of ulcer. Then on going back and cross examining the patient I have almost invariably found that suggestive symptoms were present. Hunger pain, or abdominal distress, usually epigastric, coming on about two to four hours after meals, relieved entirely or partially by food or alkali, and with periods of remission and exacerbation should always cause one to suspect duodenal or stomach pathology. The complications and coincident disease modify the story. As obstruction develops, vomiting and loss of weight become prominent symptoms. If a large hemorrhage takes place, vomiting of blood or tar stools, pallor, weakness, and possibly fainting may occur. Hematemesis is more likely in gastric ulcer and melena from duodenal ulcer. Acute perforation into the peritoneal cavity results in the well known picture. There is abrupt onset of violent abdominal pain. The patient shows evidence of shock. The pulse is usually rapid, but not always. The abdomen shows boardy rigidity. Gas may be evident above the liver as absent liver dullness or by roentgen ray examination. The temperature at first is normal or subnormal. Later the temperature rises and the leukocyte count becomes elevated. All perforations are not of this type. Some are small, the so called pin point type, and give rise to milder symptoms, which may subside in a few hours if the perforation becomes sealed off by fibrinous exudate and adhesions. A duodenal ulcer may perforate posteriorly and retroperitoneally, giving rise to symptoms suggesting perirenal infection.

In arriving at proper diagnosis of gastric and duodenal pathology the physician who takes thorough histories, does careful physical examinations, who uses the stomach tube and gastric analysis, who obtains competent roentgen ray service along with the indicated routine laboratory procedures, including stool examinations, will almost always make the proper diagnosis. A purely exploratory operation is occasionally necessary. I would like to emphasize a few diagnostic points. The most important feature of ulcer pain is its rhythm. The classic rhythm of duodenal ulcer pain is: Food, comfort, pain. That is the pain is relieved by food, recurs in about two to four hours, and lasts until the next meal when it is again relieved. It is stated by some that the above is the rhythm of duodenal ulcer and that the rhythm of gastric ulcer is: Food, comfort, pain, comfort. This would mean that the hunger pain relieves itself before the time of the next meal. For my part I will accept hunger pain relieved by food or alkali as indicative of gastric or duodenal pathology, depending on roentgen ray and other observations to locate it. There are some parapyloric lesions in which the radiologist cannot say on which side of the pylorus the location is.

Gastric analysis is important. We formerly used the Ewald meal extracted in one hour. Recently we have changed to a meal consisting of eight arrow root biscuit and 250 cc of water. The duodenal tube is placed in the stomach before giving the meal and the fasting content obtained. The meal is them given and fractional analysis done, making estimations every 15 minutes for two hours. A rapid rise in the free hydrochloric, or a primary rise and marked secondary rise to high levels is commonly noted in ulcer. It is our experience that the normal range of free hydrochloric acid is from 20 to 40 with the average about 30. The total acid in normal cases runs from about 40 to 80. The finding of blood in gastric content and in the stool is suggestive. We have not found the presence of lactic acid consistently associated with organic pathology. The amount of gastric content found in the fasting stomach gives quantitative information regarding stasis.

We have observed some ulcer cases with low gastric acidity (but not with fract analysis).

The treatment will vary according to the type of pathology present and the type and condition of the patient, his temperament and amount of suffering. The location of the ulcer makes a difference. Gastric ulcer is a more serious disease than duodenal ulcer, and has shown less satisfactory results and a higher mortality with either medical or surgical treatment. Malignancy enters the gastric ulcer problem from two angles, first, because it is not always possible to say for certain whether a lesion is malignancy or ulcer, and second the possibility of development of malignant change in an ulcer. Gastric ulcer probably does not undergo malignant change so often as was formerly thought. Hurst estimates that twenty per cent of gastric cancers develop on the sites of ulcers. Without question the treatment of simple uncomplicated ulcers of the duodenum and small early ulcers of the stomach is medical. Cases with urgent symptoms should be confined to bed, but mild cases may be ambulatory. They should recline one-half to one hour after meals, especially after the noon meal. Ulcer cases do not tolerate concentrated sweets at all well. Irritating foods, mustard, pepper, tabasco, and acids should be avoided. Alcohol should be avoided, but it is my experience that distilled liquors are tolerated better than wines or beer. Nuts are poorly tolerated. As meat extracts stimulate acid secretion and contain nothing to neutralize it, they are only harmful. Food rich in protein does neutralize acid and is most desirable. Therefore, milk and finely divided meat are important in the diet. Fat is bland and stimulates the flow of alkaline duodenal fluids, therefore, the advantage of cream and butter. Starches are well tolerated and so the ration can be well balanced. Vitamines are important and help maintain resistance. Rest, proper diet, administration of alkali between meals, and eradication of various foci of infection constitute the medical treatment of an uncomplicated case. Vaccine therapy or nonspecific protein therapy may be added.

On any medical treatment some cases will apparently recover. Many cases will continue to have recurrences. Some will perforate, have hemorrhages, or develop obstruction, and still all simple ulcers, especially of the duodenum, should have opportunity to recover on medical treatment.

Surgical treatment is indicated when dealing with complicated ulcer, with a gastric lesion which may be malignant, or with an uncomplicated ulcer which has been treated adequately medically and without relief.

The type of surgical treatment will also depend on the pathology present and the condition of the patient. A patient with advanced nephritis, serious cardio-vascular disease, or with other equally serious conditions besides the ulcer, would, as a matter of course, not be subjected to surgery if avoidable. Young patients, especially of the very nervous type, as a class, do not give the best results with surgical treatment. Patients with marked cicatrization and obstruction afford the ideal indication for gastro-enterostomy. If there is a history of recurrent hemorrhage, the lesion should be resected if possible. Active hemorrhage with acute blood loss should be treated conservatively by transfusion and other medical measures. I know that some European surgeons advise and do operations on patients with acute hemorrhage, but conservative management is generally accepted in America. Acute hemorrhage very rarely results in death. Such patients are bad surgical risks until they recuperate from the blood loss. When they have recovered, examination can be done and proper treatment given, either medical or surgical. Acute intraperitoneal perforation is a most important surgical emergency. Operative mortality is low if operation is done promptly, but high with delayed operation and the longer the delay the greater the mortality. Small or pin point anterior perforations with sealing off, or posterior retroperitoneal perforations are not extreme emergencies, but should be operated upon after taking time for thorough examination.

Opinion as to surgical management of ulcer today is divided into two schools: The first, a large group, includes many of the foremost American and British surgeons, who prefer conservative operations, most often gastroenterostomy, when operating for duodenal ulcer, and who perform partial gastrectomy for gastric ulcer, or for duodenal ulcer in exceptional cases only. The second group includes those surgeons who have adopted partial gastrectomy as the operation of choice for all duodenal and gastric ulcers. Included in this school are Finsterer, Haberer, and Hartman in Europe, and Berg and Lewisohn in America. The resectionist began by reporting remarkably unsatisfactory results following gastroenterostomy. Lewisohn reported that his follow up of gastroenterostomy cases showed the incidence of gastro-jejunal ulcer to be thirty-four per cent. Members of the radically inclined group then adopted partial gastrectomy as ulcer treatment, some on the theory of resecting enough of the acid secreting mucosa to do away with the acid erosion factor of ulcer production, others with the entirely different idea that the resection includes the area of tissue affected by gastritis and its associated infection, which they believe is responsible for both primary and secondary ulcers. The greatest objection to partial gastrectomy for duodenal ulcer is that experience has shown that is does not render the patient immune to marginal ulcer. Belfour and others have reported secondary ulcer in the line of anastomosis following resection operations. Also, judging by reports presented at the recent meeting of the American Surgical Association, results of conservative operations, including gastro-enterostomy, are not so unsatisfactory as claimed by the resectionists. I gather from these reports that the incidence of marginal ulcer following gastro-enterostomy is not over eight per cent, and that well managed conservative surgical treatment is satisfactory in eighty-five to ninety per cent of cases. It is also well to remember that operative mortality from resection is higher than that from gastro-enterostomy and that a patient who develops marginal ulcer following resection is in a much more serious condition than one with the same condition following gastro-enterostomy.

The principal late complications which may follow surgical treatment of ulcer are:

1. Marginal ulcer.
2. Recurrent hemorrhage.
3. Malignant change in a gastric ulcer not removed at operation.

Malignant change can be avoided by the resection of gastric ulcers at the primary operation.

Post operative hemorrhage from ulcer cannot be entirely prevented. However, as already mentioned, when operating for duodenal ulcer upon patients that give a history of hemorrhage, it is wise to resect the ulcer if possible.

Marginal ulcer is a serious complication.

They often perforate, and occasionally perforate into the colon, resulting in gastro-colic fistula. Until recently treatment of such ulcers has been almost entirely surgical. On opening the abdomen of a patient who has had gastro-enterostomy and who has developed marginal ulcer, careful exploration of the abdomen should be done. The original ulcer will usually be found to have healed. In that event the anastomosis can be taken down, resecting the ulcer bearing stoma, and closing the stomach and jejunum, allowing the stomach to again empty itself through the pylorus. If the original ulcer is still active, or the pylorus is not patent, it may be necessary to take down the gastro-enterostomy and do some type of resecting operation. Recently, however, good results in treatment of secondary ulcer have been reported to follow administration of mucin, giving one-half ounce one to two hours after meals. I have recently used mucin and with surprisingly good results. My experience has been with one case of suspected marginal ulcer, one case of recurring post operative-hemorrhage, and in several cases as primary medical treatment of simple ulcer. However, the time of observation has been too short to permit definite judgment as to efficiency.

In conclusion, it is very evident that no treatment of peptic ulcer is perfect. The majority of all cases will do well if proper treatment is used. There is or should be no conflict between advocates of medical and advocates of surgical treatment. Medical men and surgical men should co-operate and suit the treatment to the demands of each individual case. I do not feel that the advocates of radical resection as routine treatment for duodenal ulcer have yet shown that this procedure should be widely adopted. On the other hand I think that when surgery becomes necessary in the management of cases of theod ulcer, conservative surgical measures, used as properly indicated, will give the most satisfactory results. This attitude is supported by some of the ablest American surgeons, and my own experience seems to justify it.

From Tri-County Medical Society

(Copiah, Lincoln, Walthall, Lawrence)

On motion of the secretary pro-tem, W. H. Frizell, the following was adopted: "Resolved, That The Tri-County Medical Society heartily indorses the Community Hospital idea as promulgated by the Mississippi State Medical Association, and that we pledge ourselves to use our influence with the incoming administration to assist in effecting such legislation as in the wisdom of the constituted Committee may suggest to the Legislature at its next sitting."

We are glad to have this good news from the Tri-County Medical Society. This society has some good thinking men, men who will be influential in bringing about this much needed legislation. You are right. You may go forward and fear no evil.

American Medicine—Medical Economics*

BY S. C. BARROW, M.D.
President Louisiana State Medical Society
Shreveport, La.

In bringing to the front the question of Medical Economics, I would have the profession distinctly understand that I have no thought or wish or scheme for devising means and ways of building up the individual doctor's bank account and his financial standard, per se.

The question before the American medical profession today, and more vitally the American public in general, is whether our profession shall continue to operate as a great system, pulsating with a human heart and the individual doctor as the unit, spurred on by personal initiative and ambition, or shall we have, on the other hand, a cold blooded machinery in its stead, with the individual doctor acting merely as a cog in the wheel, attempting to operate as directed by "higher ups," with none of the personal freedom, initiative and stimulus which has characterized our activities in the past.

The former is a principle peculiar to America and has made us great: the latter is foreign to our very nature and confronts us only through the misguided efforts of mis-informed influences.

The history of medicine dates back to the almost forgotten past, into the dark recesses of Egyptian, Hindu, Chinese and Grecian lore; in fact, into the era of mythology when Apollo reigned on Mt. Olympus and sent his mythical son, Aesculapius, to earth to serve the sick and afflicted.

No profession or trade, no avocation or vocation has such ancient history. None of the religions of man date back so far, only the belief in a God paralels, or ante-dates the plans of man for the cure of the sick.

Christ came to earth and cured the spiritually and physically ill; his disciples laid aside their fishing nets and went abroad teaching the doctrines of his faith, with no thought of worldly remuneration. Yet, in this modern day we see, after only 2000 years, his modern disciples and those of other faiths, budgeted for by those communities whom they serve, and no one censures these godly men when we see them move on to larger and more remunerative fields. This is as it should be, though their budgets in most cases are niggardly small.

Tracing the history of all the trades and professions of man, from their earliest inception to this present practical day, we find the imprint of evolution in bold relief scientifically, practically.

Yet in the practice of the Aesculapean Art today, we find still clinging with a death-like grip, certain traditional teachings, influences and impracticalities born to us at the birth of history. The practice of medicine has progressed to its present high standard because of its traditions, and we can likewise truthfully say in spite of some of its traditions.

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*Read before the 6th District Medical Society, Jackson, La., October 14, 1931.

And what is the tradition of medicine which has separated it from the other professions and make it stand out as touched by the hand of God?

The teaching and practice of its members of alleviating pain where ever found, more especially in those unable to provide for themselves. However, through extraneous and selfish influences this tradition has been distorted so that we must serve any and all, with no thought of ones' self, those dependent upon us, or the future of our profession.

I hold it the duty of all men to so conduct themselves and the business in which they are engaged, in such manner that their business may increase in scope and become more useful to society in the future. The practice of medicine is our job and it becomes us to conduct it so, that it shall become more useful to humanity in the future.

I know of no machinery established in this country which will provide ways and means for maintaining the doctor at a high standard of scientific development and equipment, excepting the individual efforts of the doctor himself. Unless these individual efforts produce the ways and means, the individual doctor suffers deterioration, and when he deteriorates, general medicine deteriorates and the public, in the end, must feel the effect.

Modern civilization, if such it can be called, and modern human nature familiar to us all, tends to shift responsibilities to the shoulders of others. Slowly and by degrees, as the complexity of society has increased, pressure from without our ranks and weakness from within, has enabled selfish individuals and organizations to amend our original tradition of free service to the weak to charity service to the strong.

Tradition has been defined as the process by which the teachings of one generation are fixed upon those of the future. Applied to human activities, this practice would result in stasis and no progress. We are living in a changing world and with or without our will, we must change with it.

The audacity with which the individual and the many organized individuals demand the doctors' service regardless, must be met with the calm and dignified request for information as to where lies the responsibility.

There is no sin in the eyes of God or just men in refusing to accept as our responsibility that which rightfully rests upon the shoulders of others. The practice of our profession is our business and our only means of livelihood, and society, however small the community, must come to learn that the care of the indigent sick is just as much its duty as is the care of the indigent hungry. To shift the whole burden to the shoulders of a small group of individuals is manifestly unfair.

The doctor today pays the State of Louisiana a special tax for the privilege of practicing his profession, just as the merchant does for the privilege of selling his goods; he writes his check for the Community Charity fund, he donates to the Salvation Army fund, the Red Cross and other charity demands, just as other good citizens, and yet the community demands that he alone shoulder the burden of providing medical care for the indigent.

Where is the community, or the individual who would be so unfair as to demand of their local merchants that they assume the expense of feeding and clothing the indigent in their midst?

It is not done because distorted tradition has not so directed. When communities learn and act upon the principle that the care of the indigent, whether hungry or sick, is their problem, many of the doctor's problems will be solved and many classed as indigent will get a reclassification.

Coming in from all sides under various guises and disguises, certain activities are lopping off the sources of the doctors income, while we sit idly by playing the "faux pas" and living on distorted tradition.

Many medical men will hold up their hands in horror when the question of finances is mentioned in a medical convention, though their first thought usually is the fee in actual practice; I respect their opinions and grant them their right to act and practice as consistently or inconsistently as they choose, but where is the evil of discussing finances?

Our State and various Parish Associations in their constitution and by-laws provide, among other things, that the material interests of the doctor shall be cared for. The Great Teacher of man discussed money in many of his parables, urged thrift, the practice of economy, and in no instance did he say other than the love of money was an evil.

It is not my purpose to attempt other than to put you on your guard in the matter of the present medical economic trend.

Now the State Board of Health, I am informed by its president, does not desire or intend to enter the practice of curative medicine, but realizes the field of preventive medicine is the activity for which it was created. However, in many instances, our zealous health units are stepping out into active competition with the local profession. I have heard many complaints of this kind and in most instances, it has been shown that members of the local profession, by their assistance, have made these programs possible.

Sixty-two per cent of the hospital beds in the United States today are charity or semi-charity. Seventy-one per cent of the sick today are treated as charity, or semi-charity, and the number is mounting. Tuberculosis Clinics, Children's Clinics, Prenatal Clinics, Venereal Clinics, Outdoor Institutional Clinics, unrestrained, are operated by the doctors on a charity basis in direct competition with themselves, all because of distorted tradition.

The Legislature of our state in years gone by thought it wise to establish two Charity Hospitals for the care of our indigent sick, and we find today the wards of these institutions clogged with men and women well able to pay for their medical care, and taken care of by a staff on a no pay basis, in direct competition with themselves; distorted tradition again at work.

The medical profession of this state should stand shoulder to shoulder and demand that their work in state institutions be paid for. I know of no lawyer who advises these hospital boards, unless he is paid to do it. I know of no experts in other lines who advise without remuneration; but the doctor stands alone as the goat, because of more distorted tradition.

The City of Shreveport, and I use this city only as an example, is using our tax money to provide medical care for people who are well able to pay for medical service. Under the guise of Medical Supervision of School Children, medical service is rendered gratis where parents are well able to pay.

Neither the state, its subdivisions nor municipalities have any right to enter the field of curative medicine, except among its indigent and I hold here that it is the state's duty and in no sense that of the medical profession.

Scattered over our state from one end to the other, are corporations actively engaged in the practice of medicine, yet the State Medical Practice Act provides that only an individual who can stand certain medical examinations shall be permitted to practice medicine.

The Supreme Court of California has recently decided that corporations cannot practice medicine in that state and their corporations and methods of practicing medicine over there, are the same as is going on in Louisiana.

The Supreme Court of Kansas has recently decided that a corporation cannot practice dentistry in that state, and the Supreme Court of Illinois decreed that a corporation cannot practice law in that state. Imagine, if you can, a corporation standing an examination and receiving a certificate to practice medicine.

The Workmen's Compensation Act of this State, drawn ostensibly in the interest of the working man, is operated with an eye for dividends for out of state corporations who grind the doctor down in his charges and usually contract with the cheapest that can be obtained. This lacks good business on their part; it shows poor business and lack of good sense on the part of the doctor.

The insurance companies have no legal right to practice medicine, neither any corporation in our state, as is being done and a test of their right must come sooner or later. I have no knowledge of law and its intricate workings, but there is a broad principle underlying our legal structure, I am informed, which provides that no individual, or concern shall be permitted to do indirectly those things forbidden directly.

Thus we could continue ad infinitum, to cite instances of such nature. We could point to the action of our national government where spineless vote seeking congressmen and senators have yielded to pressure from certain influences in the American Legion and are now providing mdical care to all members of that body, regardless of the fact that their illness has no connection with their service during the war.

We could point to the practice of that wonderful organization, the American Red Cross, which during a devastation, go into a community and supply every need of the unfortunate, except his medical care, and leave the local profession to carry the load alone.

Thus by degrees present conditions, practices, and ideas have become established, and after all is said, what is to be done?

We cannot sit idly by, admitting that the problem is too big to be tackled, as I have heard certain men cringingly admit. The solution is simple, though of course somewhat difficult of application.

Organization and square dealing, one with the other, can accomplish relief from most of our ills.

Our code of ethics as handed down will never be construed by an enlightened public as demanding certain present day practices and impositions. The public must be told and taught the facts. Distorted tradition must be brushed aside and the white flag "No Charge" must float aloft only when emergencies exist and our neighbor has shouldered his portion of the load.

PROGRAM AND INVITATION

You are Cordially Invited to Attend the
Regular Quarterly Meeting of the

Northeast Mississippi
13 County Medical Society

to be held in the First Methodist Church
at Tupelo, Mississippi
Tuesday, December 15, 1931—7:00 P. M.

—PROGRAM—

1. Meeting Called to Order .... Dr. C. E. Boyd
2. Invocation .... Rev. Buhrman
3. "The Acute Abdomen."
   Moving Pictures of Goiter Operation.
   Dr. W. D. Haggard, Nashville, Tenn.
4. "The Vomiting of Pregnancy" .... Dr. C. B. McCown
   Discussion Opened by Drs. Eason and Deanes
5. "Surgical Dilemmas" .... Dr. E. Q. Ewing
   Discussion opened by Drs. Philpot and Ivy
6. President's Address.
7. Business Session.
8. Election of Officers.
9. Banquet, Tupelo Hotel.

African Hunt, with Motion Pictures,
Dr. Casa Collier, Memphis

President, 1932, comes from Lee County

A Few Observations Relative to Our Medical Problems

By FELIX J. UNDERWOOD, M.D.

From an economic standpoint, the health of a nation is of paramount importance to its progress. Every industry, business, or occupation suffers considerable financial loss by ill health of its workers. The health of a nation is of vital concern to its government, good health is an asset of the greatest value, and as an asset which can be attained, it becomes a national responsibility requiring the same care bestowed on it as any other sphere of government work. Practically every government of the present day has its special department and minister dealing with health matters.

From an editorial in the Journal of the American Medical Association, I quote the following:

"A wide variety of views is offered regarding the problems of the medical profession in relation to the public. The adequacy of existing curative and preventive medical services and their effectiveness are being questioned. To these problems the Committee on the Cost of Medical Care is giving careful consideration. It has become imperative to secure facts lest a tragedy of errors supervene. The Commission on Medical Education, organized under the leadership of President Lowell of Harvard University, has already reported an extensive study of the demands and needs for medical service, in part by sampling the demands on general practitioners in communities small enough to give a clear picture of general practice. The preliminary surveys indicated that about seventy-five per cent of the office visits were for minor surgery, upper respiratory infections, and general medical and veneral diseases. About ninety per cent of home visits were for infections of the respiratory tract, general medical and contagious diseases, obstetrics and minor surgery. More than ninety per cent of the illnesses are of types that cannot be controlled on a community basis but are problems of individual patients. Less than ten per cent are diseases against which public health efforts are mainly directed. This fact is an index of the growing efficiency of public health efforts and emphasizes the necessity of treating the patient as well as the disease. The common causes of disabling illnesses and absenteeism correspond closely with eighty per cent of the combined office and home visits of the general practitioner. The dullness of ordinary statistics is lost in some of the discoveries of the Committee on the Cost of Medical Care. They indicate for this country that people are, on the average, disabled by illness at least once annually, men about once a year, women from once to twice, and children more than twice each school year (of 180 days). On the basis of the lowest rate for disabling illness found by the United States Public Health Service, there would be about 130,000,000 cases of disabling illness in the United Statee each year and, if non-disabling illnesses should be added, this figure would be more than doubled. What this may mean is indicated by the conclusion that the 36,000,000 wage earners in the United States lose at least 250,000,000 work days a year and that 24,000,000 school children lose 170,000,000 days each school year. These figures take into account only half of the total population. Numerous surveys have indicated that colds and bronchial conditions, and influenza and grip, are obviously the most serious causes of disability from the standpoint both of frequency and of days lost. On the basis of both the number of cases and the total time lost, digestive diseases and disorders loom large. Diseases of the pharynx, tonsil and larynx—including adenoids, tonsillitis, sore throat and croup—are also of considerable frequency and severity. Then non-venereal diseases of the genito-urniary system and adnexa receive prominence in the list, largely because of the frequency of cases of dysmenorrhea among women and girls; but included are acute and chronic kidney diseases, which each year cause an increasing percentage of the total mortality. It may not be an agreeable reminder, but the medical profession must nevertheless face the warning that in 1928 there were nearly 2,000,000 births in the registration area, many of them followed by complications and a considerable number (a larger proportion than in most civilized countries, by death. On the other hand, the public and particularly a small obstructive group of anti-vaccinationists, should properly bear much of the odium of more than 36,000 cases of smallpox reported in a recent year. According to these complications, special estimates place the number of persons in the United States who are mentally defective (feeble-minded, imbeciles, and idiots) at more than 900,000; the number of blind at more than 100,000; the number with major speech defects at 1,000,000 and the number of school children wholly or partly deaf at 3,000,000. This country is by no means oblivious of the great problems here presented. There are in United States more physicians per thousand people than in any other country in the world. Hospital beds and clinics show rapid rates of increase, clinics, having the most spectacular growth of all. Hospitals other than those for nervous and mental diseases contain, on an average, more than 350,000 patients at all times. The total in all hospitals on a single 'average' day is about 700,000. Such striking figures, even with their admitted incompleteness, justify the reminder of Mills of an extent of illness and physical and mental defectiveness in the population which causes an incalculable amount of human suffering and economic loss. Some of these diseases and conditions, Mills adds, rob the nation's people of their vitality and destroy their efficiency; others lead to suden death and the premature cutting of life. This continuance of disease, part of it preventable, indicates a field for the more widespread and efficient utilization of preventive and curative measures now known."

Much has been said recently about state medicine. It might be well for us to briefly consider and review this subject: State Medicine may be defined as a system whereby all physicians are educated under state control and are salaried by the state. They are to be supported through taxation and receive no direct compensation from their patients. Medical education would be controlled and directed by the state. Practice would be supervised by the state; salaries would be fixed by the state and in proportion to the responsibilities assumed and skill expended. The doctor would be assigned to definite localities, postgraduate courses would be provided and required, vacations would be granted, and there would be pensions for physical disabilities and old age.

We would have none of the overcrowding of the cities and neglect of the rural communities for the doctors would be allocated in accordance with the needs of the communities. There would be none of the nefarious practice of fee splitting because there would be no fees to split. There would be no unnecessary services performed for reasons of financial reward and patients would be referred to the doctor most competent to perform the service rather than to be retained in less competent hands. It is argued that public school education was once more bitterly opposed than is state medicine. And now we have public education and it is costing the taxpayers the tidy sum of not less than two billions of dollars annually. The proponents of state medicine affirm that it is as much the business of the state to prevent and cure diseases as it is to educate our youth; they argue that free education does not pauperize, nor will free medical service. Fifty years ago there was little supervision over medical practice. Now we have state control of licensure. We have industrial commissions. Every community has its health officers, the state provides for the care and instruction of the deaf, the dumb, and the blind; the cripple, the mental defectives, and the victims of venereal and contagious diseases are cared for by the state. The government as well as many private organizations are engaged in educating the public in health problems. We have adjusted ourselves to these obligations and they are generally approved by the medical profession and the public. If it is the duty of the state to provide for these exigencies, why, we are asked, should not the state provide for the acutely ill and injured; for the rich and poor alike? The public schools are open to rich and poor alike; police protection is provided and without class distinction. Why not medicine? Formerly the medical profession was solely concerned with the cure of disease; now the prevention of disease is of most vital concern, and is this not the duty of the state? Traveling clinics, at the expense of the government, are supplying medical services to the widely scattered communities in Alberta. The panel system has long been established in England and is fairly satisfactory to the profession and the public. In Germany, 40,000 doctors are employed by the government and two-thirds of the German population receive medical services and hospital accomodations from the state. The maximum income of a doctor so employed is $50,000. In the Canal Zone there are no private practitioners, no cults, no "patent medicine." All is under government control. Preventive medicine has made the Canal Zone one of the healthiest places in the world. In support of state medicine it is contended that most advances in medical science are made by salaried men and that this will be increasingly so in future years. In support of the contention that state medicine is an economic necessity, it is estimated that there is an annual expenditure in the United States of $700,000,000 for drugs, $2,000,000,000 paid by industries for illness, $6,000,000,000 for lives needlessly lost, $1,200,000,000 for hospital maintenance, $90,000,000 for funerals and only $65,000,000 for public health.

Advocates of state medicine are wont to refer to the Army and Navy Medical Corps as evidences of governmental efficiency in medical affairs. It is contended that, under state medicine, granting that the government would reward the doctors as liberally as it now does the Army and Navy Medical Corps, physicians would be better compensated than they are now in private practice. It is the specialists with larger incomes who would suffer under state control. It is predicted that state medicine would abolish quackery and secret nostrums and that it would foster research in the cause, prevention, and cure of disease, and to a greater degree than is now possible under private direction. The sparsely settled portions of our country are inadequately supplied with doctors and hospitals and it will be the duty of the state to provide facilities for these outlying districts where the private practitioner could not eke out a living. There will be traveling clinics such as are now to be supported and directed by the state of North Carolina for the benefit of rural communities. Medical education is acquired as great expenditures of time, labor, and money. Seven to twelve years of such sacrifices are scarcely justified in the prospect of a salaried job such as state medicine could offer. Admitting that the rank and file of the profession would be better rewarded in state medicine, there would be little incentive to make the necessary preparation for a distinguished career. Take away individuality and you destroy the initiative. State medicine cannot change human nature, though it change human relationships. Independence in medical pratice is an essential to the happiness and prosperity of doctors as is independence in citizenship. There will always be independent practitioners. In the main they will be the most progressive and competent. State medicine will attract the weaker elements of the profession. Those who are able to pay the price will continue to employ the private practitioner. Those who cannot pay will receive the services of the profession as they now do.

Legitimate all-time public health service in the prevention of all preventable diseases in our deliberate judgment is the best insurance policy against state medicine. The profession should support legitimate public health work for the people but fight with all their might against state medicine, for—with the amazing results which properly conducted public health activities is able to show, with the profession adjusting itself to meet the needs of all classes of citizenship demanding fair treatment from them and while refusing to unduly cater to and pauperize them, yet accord them fair consideration, All Will Be Well.

Disease incidence in Mississippi—cases of and deaths from.

Cases	1920	1930	Deaths 1920	1930
Malaria	118,376	50,477	722	281
Diphtheria	2.225	1,273	282	156
Tuberculosis	4,180	3.067	2.271	1,750
Typhoid Fever	2,614	1,239	342	238
Scarlet Fever	1,610	885	20	16
Smallpox	3,148	312	44	2

It is to the credit of our profession that its members have interested themselves actively in good government, and especially in those functions that have to do with the physical well-being of man and that involve applications of medical art and science both in the prevention and the cure of the diseases which afflict mankind.

There is not a single point at which public health and private medicine cannot march forward in peace and good will. Our profession is traditionally committed to the prevention, as well as the cure, of disease. Out of its early labors arose the first slender shoot of this magnificant tree of health that is beginning to bear good fruit today. From its membership have come our foremost public health leaders. Be it said to the everlasting credit and to the honor of American physicians that they are watering, fertilizing, and protecting this tree of life in the midst of the garden of our united effort against the insects and poison bugs of ignorance, superstition, and of rampant quackery, which establishes so-called health institutes, health homes, advertises so much about your health and often puts it over on a gullible uninformed public and yet knows little or nothing of medicine, either curative or preventive, notwithstanding the fact that they pose as physicians and talk glibly and advertise freely to prevent and cure all diseases which afflict the race. They bitterly oppose the principles and practice of preventive medicine, denouncing immunization and vaccination. They profess not to believe in the germ theory of disease, yet so ignorantly inconsistent are they that most of them tell people that immunization and vaccination cause many diseases, such as syphilis, typhoid fever, meningitis, and within this week I have had otherwise intelligent people call me and tell me what some quack said about it.

Do we need a consistent, persistent program backed up by the physician one hundred per cent for the enlightenment and for the protection of our citizenship in every county, in every community, in every home, and with every individual in our State? Do we? Health education like Christian education is a real job in this day and time when evil forces are presenting a united front. We must stand united in our efforts or we fail miserably.

The most obscure physician gives some portion of his energies to the conservation of health and usually leads his voice in support of public health measures.

The most obscure physician gives some portion of his energies to the conservation of health and usually leads his voice in support of public measures.

Lack of information is a universal fomenter of strife. For the physician disciplined in diagnosis and therapeutics, the private relationship between patients and practitioner circumscribes his horizon. That medicine also fills a public relationship, in which the good of the individual may frequently be submerged by the greater welfare of the group, is outside the compass of his vision. He is unwilling to admit that a mass of information and a technique have grown up within the realm of preventive medicine and sanitation that are generally ignored in our medical schools, yet are just as valid as the subjects regularly taught. The smattering of so-called "hygiene and public health" that was forced on him in student days appears to him to comprise all that is or needs to be known. Every health officer is acquainted with private practitioners who freely admit their ability to fill any public health position with distinction with no previous training. A mind that is permanently closed to new knowledge in other spheres than its own will discount all such new ideas as negligible or subversive of the regular order. Even the physician with a reasonable flexible mental apparatus is often amazingly uninformed of the first principles in preventive medicine and sanitation, a field so closely allied to his own that curosity alone would seem to compel superficial acquaintance. Out of this lack of information grows resentment toward even the simpler routine procedures of common sanitary practice. An attitude is created which evinces itself in unthinking resistance to all that bears the label of public health. Fortunately, this inertia is not often found among physicians.

However, not all of the blame is on one side. The public health worker must share some of it, for he fails many times to make any effort to enlighten the physicians within his field as to his plan and methods. A full explanation, at the outset, would usually convert medical opposition into acquiescense, at least, if not hearty support. His first duty is to educate the doctor, for we are all laymen outside our own specialties. In this, as in every succeeding step of his program, the utmost tact is essential. Painful memories rise to haunt the health executive who has had under his direction any number of workers. He has seen, more than once, an initially friendly group of medical men turned into enemies of the entire health program through rudeness, arrogance, superciliousness, bad temper, or lack of public health training on the part of a new worker. The medical profession has suffered much at the hands of such as these. Unsound judgment in selecting a project. or offensive methods of promoting it, will also alienate friends.

Of one cause of medical opposition, selfish, mercenary motive, the less said the better. But all experienced health officers have felt its force. The physician of this caliber is so frequently aggressive and "unsuccessful" that he holds an influential position in his community. By underground methods he can defeat an honest, well considered project without revealing his hand. That he fears the specter of diminished business is simply evidence that his selfishness is matched by his ignorance, for the real all-time well trained health officer is a press agent of scientific medicine.

Granting them that there is sometimes divergence of interests between public and private medicine, where there should be convergence; that there is antagonism where there should be accord, it will be profitable to consider its effects. They will manifest themselves in two directions: retardation of sanitary progress in many quarters, and a growing distrust of the medical profession on the part of the public. Enough examples have been given earlier to clarify the first point that lack of medical support, or active opposition, will delay legitimate public health developments. But the effect of this attitude on the lay mind may not be so evident to the private practitioner. To the medical health officer, standing midway between him and the public, a view in both directions is possible. He catches a sense of frustration and of growing exasperation among the laity, that is not revealed to the family doctor so freely. He finds the public demanding more service while his medical colleagues criticize what is already given. He realizes that the public is often more fully sold on the health program than is the profession. His dilemma is sometimes acute. As a public servant, his duty is to do the public's will. Yet, if he accedes, it will bring to light the reactionary tendency of the medical group. He feels himself a Judas among his brethren. If such a crisis arises, as it has repeatedly, the layman develops a distrust of the physicians; he is openly critical of their motives and his resentment is likely to be extreme. Are not the proposals for health insurance partly the result of just such a process? Are they not the grasping of the public after some method whereby the benfits of curative and preventive medicine may be made available to all, and at once, without waiting for the medical profession to arrive at a broader social outlook? This is not the sort of thing that the great body of health workers desires, but is a very natural reaction of enlightened public opinion. "Phantom" this public opinion may sometimes be, but it is a ghost that takes on substance as it gains momentum.

If the discussion so far is a correct interpretation of trends, some solution is sorely needed. Not that we may hope to change human nature, if the fault lies there, but that we may try to bring about more intelligent understanding on both sides and a resultant solidarity now lacking. Beginning with his earliest medical training, the student should be made to see how his subjects are related to public health. In bacteriology he can learn the uses and duties of state and city laboratories, the methods pursued by them and interpretation of their reports. Lecturers on practice of medicine ought to lay more stress on sources and modes of infection, on ordinary control measures, and on the duty of the private physician to protect the community as well as his patient. Courses in pediatrics open the way to the whole field of child hygiene while obstetrics holds the same relationship to prenatal and maternal hygiene. Medical jurisprudence embraces legal aspects of the practitioner's public health functions. And, lastly, the course in preventive medicine, hygiene, and sanitation should be the point at which these strands are woven together; where the embryonic doctor sees the whole public health field and comprehends the fact that he has a prominent and inescapable position in it. Do we have such correlation in our medical courses today? Hardly. Most of the men who are teaching major subjects in the schools are themselves lacking in this vision. Can more be expected of the people when their leaders fail?

The medical practitioner has a real place in the public health field. As a matter of fact, preventive medicine is going to consume an even greater proportion of his time. This does not mean those ordinary things that are expected of every conscientious doctor such as early biologic preparations, efforts to protect the community against the infection of his patient, and occasional help in various clinics for the indigent. These he does now to a greater or less degree. But preventive medicine has taken on a broader meaning in recent years. There has come a realization that humanity can be made healthier, and happier, by the early detection and correction of minor deviations from normal, than by curative measures applied after these conditions have produced gross pathology. "Positive health" is as good a name as any for this new objective. And the family doctor is its prophet. Better than anyone else, he can, if he will, make the next generation more fit than its predecessor. This calls for a personal relationship that no governmental agency can so satisfactorily provide. Opportunity is in the making for the private practitioner to take his own peculiar place in the public health movement. Technical preparation there must be, exactly as one would fit himself for any other special procedure. A new approach, a new viewpoint, must be acquired. He is dealing with a well man who wants to keep well.

The health officer prepares the way by education and the physician should make ready for the future that lies in that direction. The American Medical Association has repeatedly endorsed this program. Likewise, state and county societies here and there have caught the meaning of it. But until the man in general practice makes it a real part of his everyday business, it will remain only a pleasant topic of conversation. This is the challenge of the sanitarian to the private practitioner.

Wrapped up with these matters that have been touched on are problems of the medical profession far more profound and significant. What does it mean that there is an active demand in some quarters for a kind of state medicine? Why do we see such contemptuous disregard for the fine fruit of scientific medicine, while any new and blatant cult receives enthusiastic welcome? Opposed as these two trends may seem on the surface they arise from a common source; lack of socially minded leadership within the profession. Broadminded, strong, resourceful leaders can point the way and can knit our individualistic membership into a well co-ordinated group for the solution of these difficulties. Without that, we have forced on us a ready-made scheme of social medicine.

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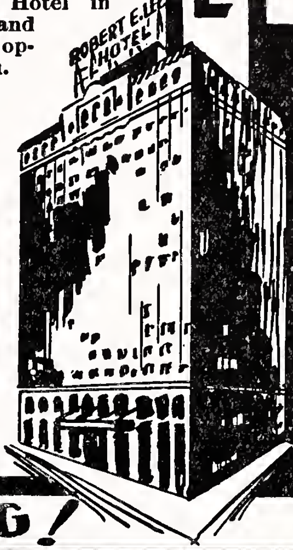

FREE PARKING!

In other words, the public wants and demands a complete program of health and healing, of which every individual may have the benefit without undue sacrifice, and it is going to have its way somehow. We have the requisite knowledge and skill. Are we intelligent enough to co-operate in meeting this need with a plan of our own devising?

Book Review

"Health Protection for the Pre-school Child" is one of the White House Conference publications, published by The Century Company, of New York. This most illuminating survey recounts the intensive data from 156 American cities which made up the report before the above conference of the preventive medical and dental service being rendered the children under six years of age—the pre-school child. There were four major preventive measures employed to cover the work that is done for the health of the child; namely, periodic examinations, immunization against diphtheria, vaccination against smallpox, and dental examinations. Charts figure alongside the discussion of the survey, indicating accurately and comprehensively the percentage status of these measures. A median area, or Midway City, struck the balance geographically and economically between the cities compared, as well as between urban and rural statistics. It is a significant fact that in only very few instances did a report exceed the 50 per cent mark in the children reached.

Detailed information is computed and outlined for the use of the organization which undertakes the health protection plan followed by the White House Conference. Explicit directions are laid out for supervisors in the urban and rural work, including the discussions for family interviews and model forms for recording the survey. This book is the replete information of the Conference on the Child Protection division of its work. It is an invaluable addition to your books on the pre-school child.

Price $2.50. The Century Co., N. Y.

"Every time I have an argument with my wife I enter it in a diary."

"Ah, I see. You keep a scrapbook."

Customer—Chicken croquettes, please.
Waiter (calling to kitchen)—Fowl ball!

The above is the graduating class of '31 of the Northeast Mississippi Hospital located at Booneville. As they appear, from left to right, Misses Artie Booth, Ruby Allen, and Pauline Morgan have completed the requirements imposed by the hospital for the degree of Registered Nurse. This month they will take the state board examinations, after which their titles of R. N. will be justly awarded.

Miss Morgan is from Tishomingo, Miss Allen from Dennis, and Miss Booth from Burnsville. Booneville and the home towns from which these young women come are duly proud of the career for service they have undertaken, and congratulate them on the fine manner in which they have equipped themselves.

Dean Mull Explains

OXFORD, Miss., Dec. 6.—Informed that some misunderstanding exists relative to the status of the University of Mississippi medical school since the meeting of the Association of American Medical Colleges in New Orleans Nov. 30 to Dec. 2, Dr. P. L. Mull, dean of the school, tonight issued the following statement:

"The University of Mississippi medical school is still on probation, doing A-grade work, and its sophomore students will be able to transfer to the junior class of other class A schools next year without examination.

"At the executive session of the A. A. M. C. in the Roosevelt Hotel at New Orleans, Tuesday night, Dec. 1, the association unanimously passed resolutions congratulating the faculty of the medical school, the alumni, the State Medical Association, the State Educational Association and all others interested in higher education in the state for their splendid and heroic efforts in the interest of high ideals in education in Mississippi, and continuing the medical school on probation for another year.

"This is all that we asked of the association and meets with the approval of the parties concerned in the welfare of the medical school."

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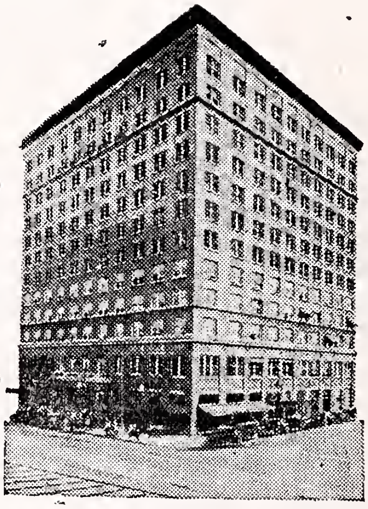

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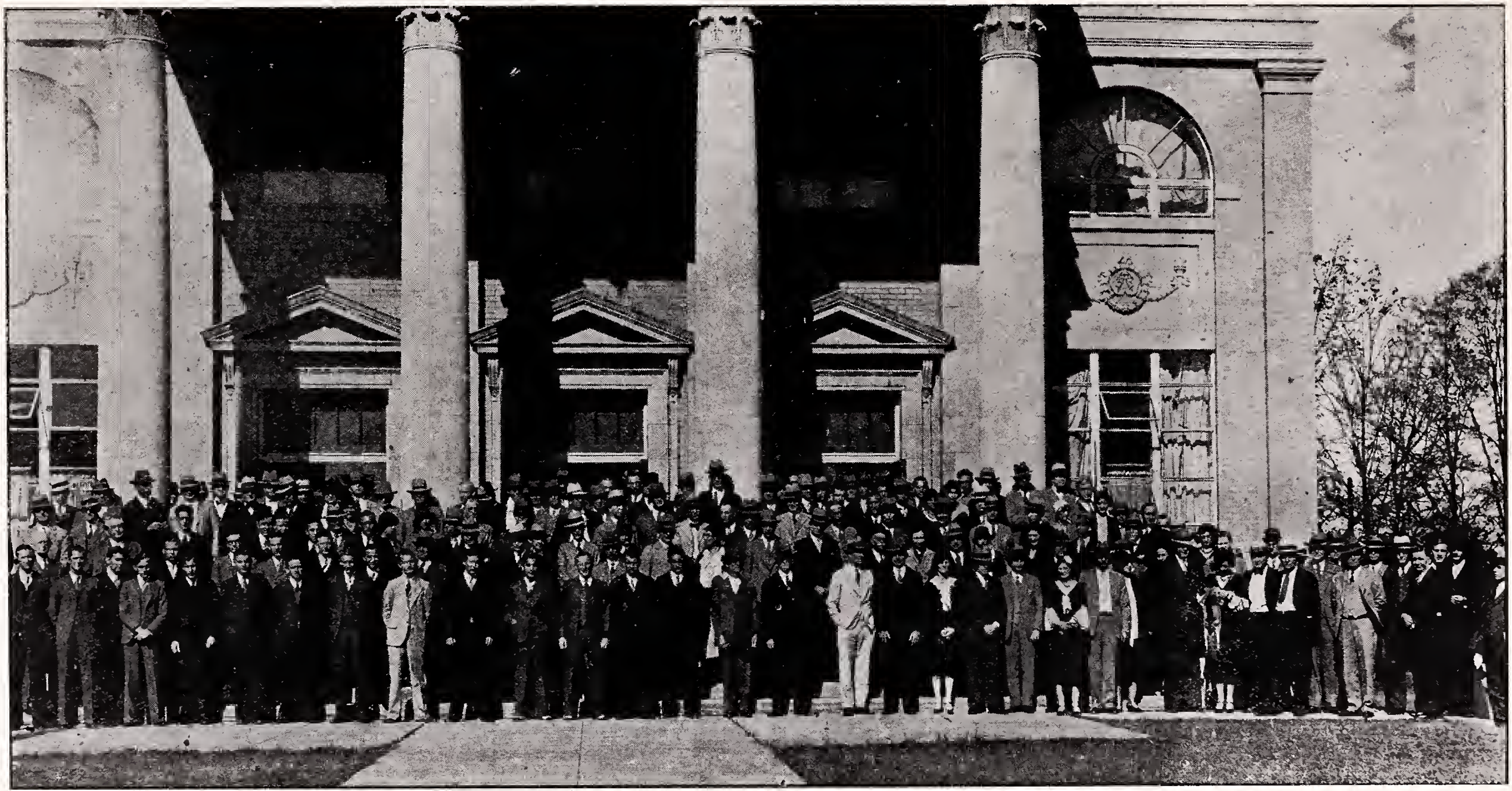
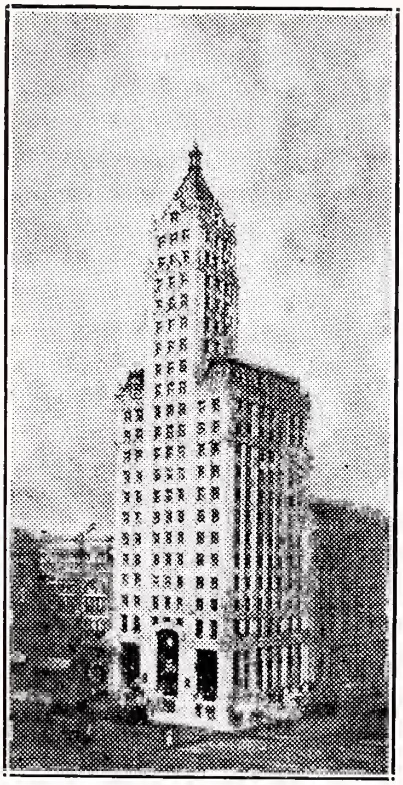


THE OLE MISS GET-TOGETHER MEETING, OCTOBER 22, 1931.

The above is a picture of those who attended the recent get-together meeting at Ole Miss in honor of Dean Mull and President Culley. The background shows the Medical Building at Ole Miss.



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Members of the Medical Profession can truly be called "watch dogs of the human race." Not only have their experiments in science and skill in mastering the technique of physiological treatment prolonged the life of man, but countless suffering gives way to their administrations.
Our most sincere hope is that this institution may work hand in hand with that profession which it knows as a splendid ally.

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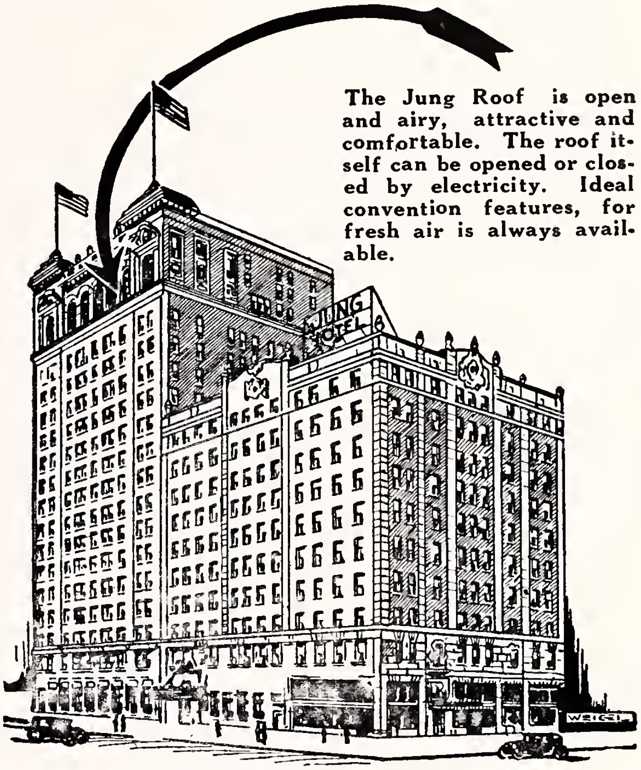

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Check Up on the Economy of these Services

A large free parking ground, the largest in the South, is at your disposal. Every room at the Jung has a servidor, saving countless dimes of useless tipping. You can get a wonderful five-course 50c. lunch and an eight-course $1.00 dinner served on the Roof, eighteen stories above ground, above noise, dirt and confusion. You can get these same meals, and also your choice of eight Club Breakfasts from 40c. to 65c. served in a ground floor restaurant at the same price, and you can also have them served in your room without extra service charge. You can enjoy a luxurious Turkish Bath for $1.00. You can get your suits pressed for 50c., cleaned for $1.00; your shirts laundered for 20c. and 25c., collars 4c. Your valet service and your laundry can go through your servidor, saving a tip going and coming. You sleep on a luxurious inner spring mattress. You can lounge, in your leisure time, in a lobby that is only comparable to the living room of a beautiful home. Every employee of the Jung is competent and willing, and is always at your service. Why not check up on what the Jung Hotel offers for your patronage.

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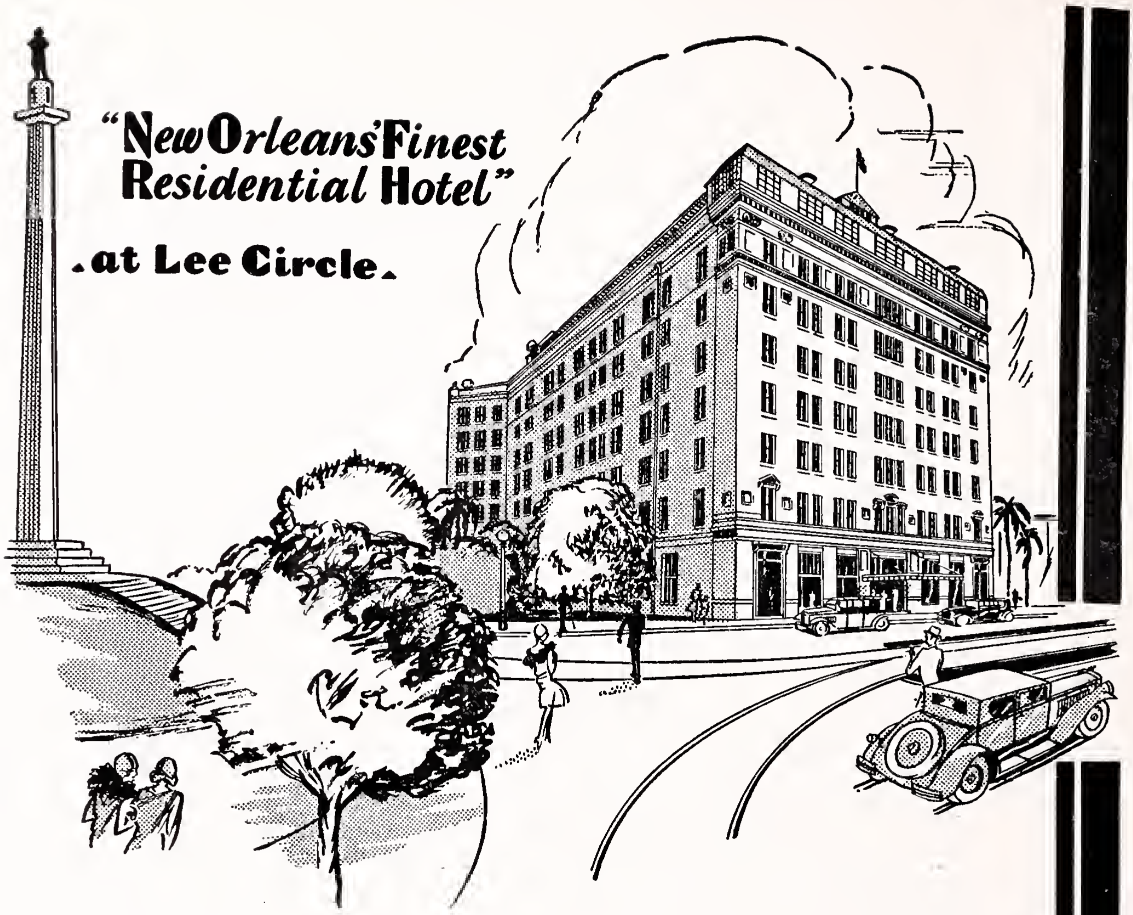
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THE MISSISSIPPI DOCTOR

VOL. 9. BOONEVILLE, MISSISSIPPI, FEBRUARY, 1932 NO. 8

On To Booneville—Tuesday, March 15th

Making the Fight

"When things go wrong, as they sometimes will,
When the road you're trudging seems all up hill,
When the funds are low and the debts are high,
And you want to smile, but you have to sigh,
When care is pressing you down a bit,
Rest, if you must—but don't you quit.

Life is queer with its twists and turns,
As every one of us sometimes learns,
And many a "failure" turns about
When he might have won had he stuck it out;
Don't give up, though the pace seems slow
You may succeed with another blow.

Often the goal is nearer than
It seems to a faint and faltering man;
Often the struggler has given up
When he might have captured the victor's cup;
And he learned too late, when the night slipped down
How close he was to the golden crown.

Success is failure turned inside out—
The silver tint of the cloud of doubt,
And you never can tell how close you are,
It may be near when it seems afar;
So stick to the fight when you're hardest hit—
It's when things seem worst that you mustn't quit."

—Winona Times.

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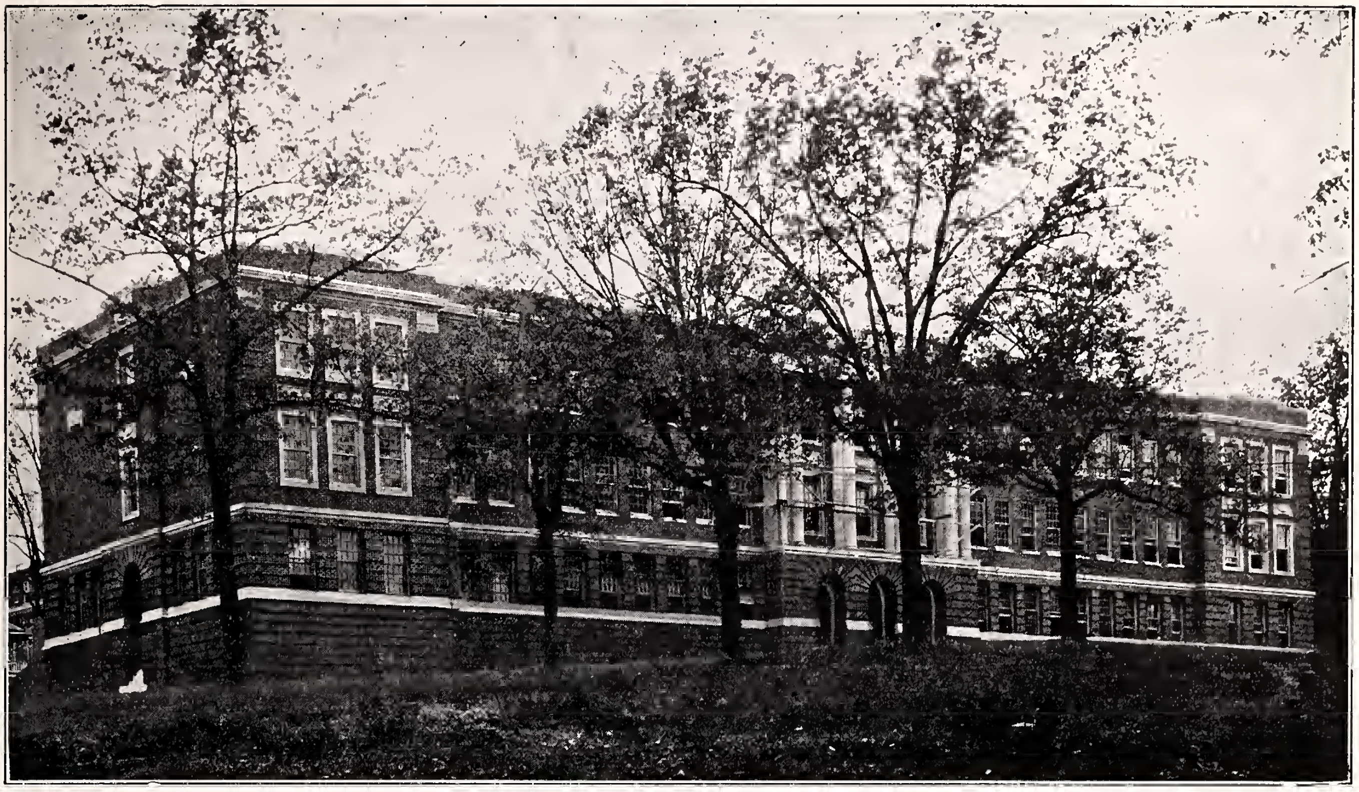

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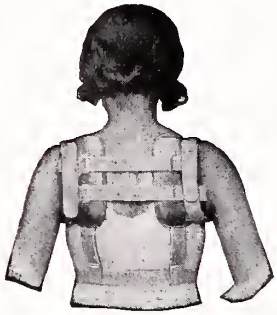

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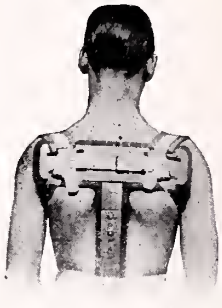

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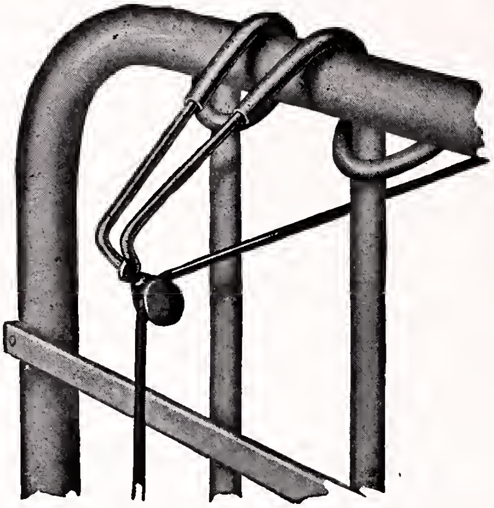

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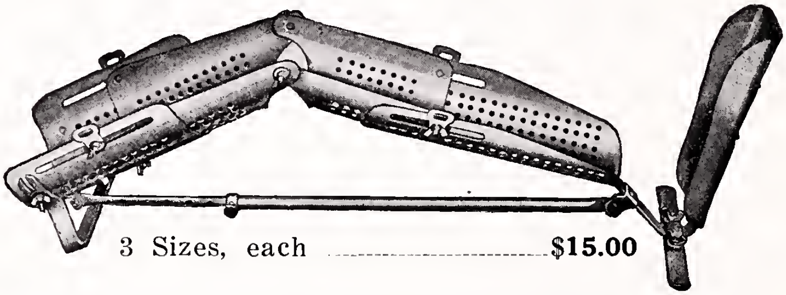

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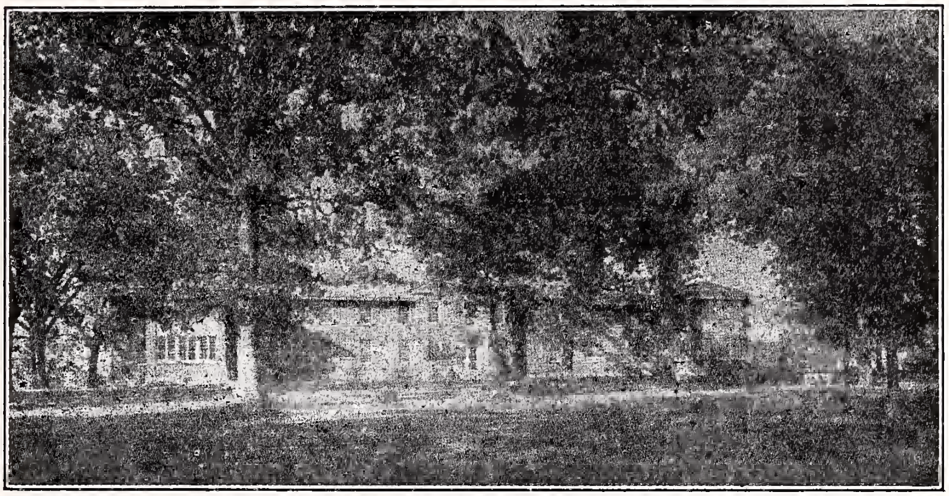

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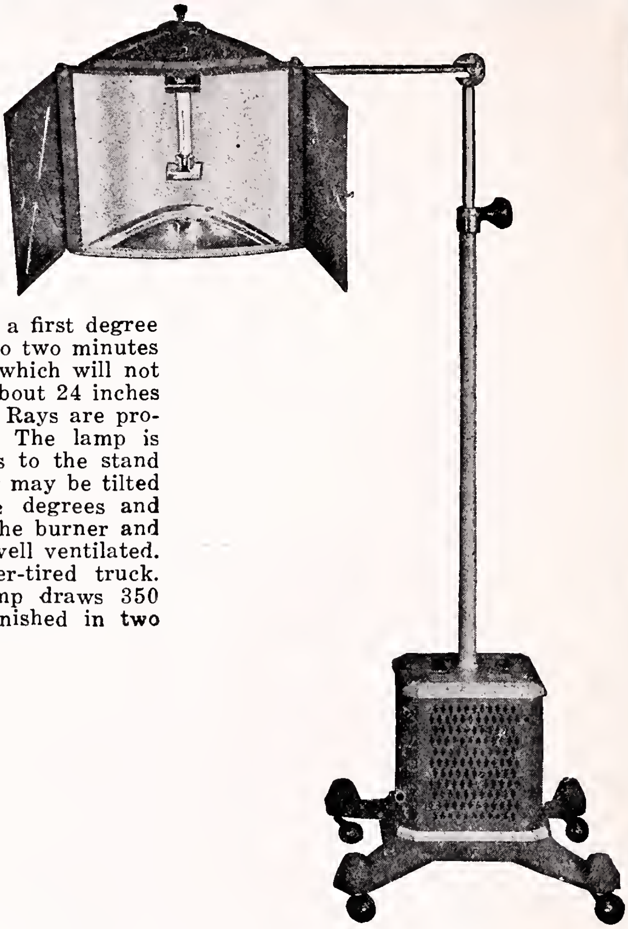

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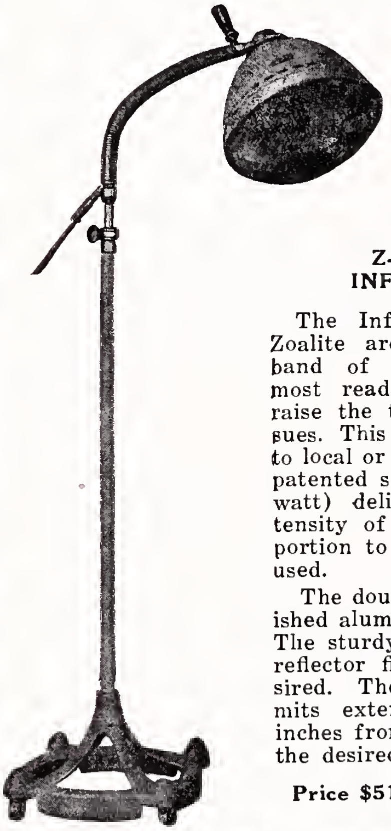

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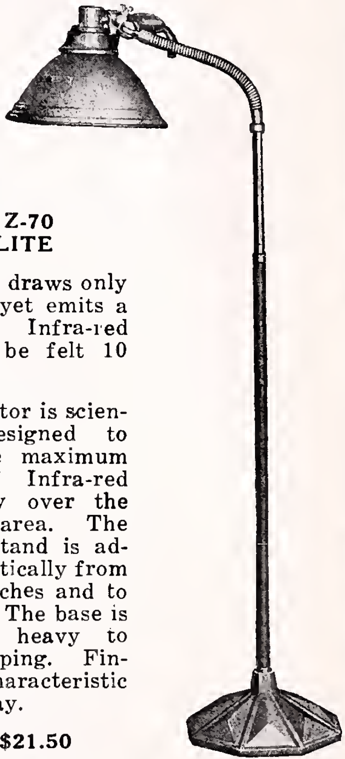

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Mississippi needs the medical school at Ole Miss, the two year course. It has rendered a fine service in the past. It can do the same in the future. Every member of the profession should rally to it at this time. Its past record challenges the admiration of the rich, its reasonable fees smile at the young man of moderate financial means, but has a burning desire for a medical education, one who has a professional mind, a medical soul and a missionary heart.

The "Mid-South" pays the expenses of its essayists. This is one of the secrets of success. Many of our very best men are called upon so often to travel long distances that they are unable to continue to go and pay their expenses. The exhibitors at this association pays a large part of the expense. The exhibitors play a big role in the success of a medical association. They and the profession should work hand in hand. The Mississippi State Medical Association should have charge of the exhibits. We should enlist their co-operation in helping to build up our association and make it better.

Dr. Morris Fishbein appeared as the after dinner speaker at the banquet on Thursday night at the Mid-South. He is a most interesting speaker, is resourceful, and drives his points to his hearers as with a pile driver.

The Mid-South Post-Graduate Assembly was a big success under its new name. It gave the last word on almost every phase of medicine and surgery in this four day meeting.

We are delighted to have a nice new ad from the Tutwiler Hotel of Birmingham. You will love this hotel. When you stop there you will like to linger. Its atmosphere is charged with the spirit of Birmingham, a rapidly growing city and one of the favorites of the South.

Dr. Edward Podolsky of Brooklyn, N. Y., who has been seeing copies of The Mississippi Doctor, evidently sent us a paper on the uses of iron in medicine. He does not go into the diet side of supplying iron very much, but gives a discussion on iron as it is used in medicine that we would do well to read and think about. Iron in therapeutics is coming back to a certain degree. It will never hold the place it once did perhaps because it will be supplied by proper diet in advance. Infections will be treated and prevented and the blood will not be so impoverished. But still it has a place and we should not forget this. We thank Dr. Podolsky.

Dr. Ewing's paper at our last meeting created a lively discussions. This is a fine paper and the discussions were most helpful. You will read the paper with the discussions with interest and profit.

We are delighted to have a paper from H. D. Chipps, D. D. S. of Corinth. Dr. Chipps is one of the leading dentists of the state. He has studied the relation of infections of the teeth and gums to constitutional diseases. He gives splendid advice on the care and prevention of the teeth, how to prevent decay and how to have good sound teeth. There needs to be more co-operation and closer prefessional relations with the dentist and the medical profession. In fact, the dentist, the pharmacist, and the nurse must be utilized more than ever by the physician if he is to go forward as he should in the profession. The physician needs the dentist every day to help him make a diagnosis. Every one knows the value of a well trained nurse who knows the science of nursing, who is full of optimism and who is a good psychologist. And the pharmacist is a great power behind the throne to many a practitioner of medicine. It takes all four to make up the medical profession. With these professions let us have a more thorough correlation and a more sympathetic co-operation. We thank Dr. Chipps for his paper.

Skin disease is the big black night mare to almost every general practitioner. We are glad to have a paper from an outstanding man on skin disease, Dr. Henderson of Memphis.

Don't fail to read the little poem on the front. We are sorry we do not know the name of the author. It is very appropriate at this time. Read it and take courage. It is the man who can keep on keeping on who wins. The man who has the glue in his innards to stick like a postage stamp will weather the hard times.

The question is whether you are going to pay your medical dues or not pay them. When times are hard, and dollars are few, remember your profession and remain true by paying your dues. It is hard at this time to be sure. But you did not look for an easy job when you took up the practice of medicine. It develops self respect to do hard things. You are due to devote some of your time and some of your means to the promotion of organized medicine. It pays you big returns. No other science has grown and developed so rapidly as that of medicine. You must spend money and time to keep up with the progress. The one thing of greatest importance is to pay your dues to you local society. You can not point to a man who has grown very big in the profession who has not belonged to his local society and paid his dues. It just puts you on the wrong side and you do not have the working spirit that you would have. As a general rule the man who does not attend his local society and pay his dues does not render as good service to his clientele. He is not improving his talents as the Lord intended. His knowledge wanes, what he has, and is given to the man who takes an active interest in his local society helping and being helped. With an outstretched hand and a pleading heart we bid you come on over into Macedonia and pay your society dues-help us and help yourself.

You will note a list of the essayists of the Southeastern Surgical Congress which will hold its third annual session at the Tutwiler Hotel in Birmingham, March 7-8. This assembly offers a wonderful program. It offers a fine opportunity for surgeons of Mississippi. This assembly bids fair to render a great service in its selected territory.

Martin H. Fisher of Cincinnatti appeared twice on the Mid-South Program. He was thoroughly enjoyed on both subjects. When it comes to combining real medical science, human philosophy, and common sense Dr. Fisher takes the cake every time he goes to bat.

Don't fail to read what President John C. Culley has to say relative to the editorial in the Jackson News. The registration of birth is of the greatest importance.

Mid-South Assembly Elects

New officers elected by the Mid-South Post Graduate Medical Assembly were: President for 1933, Dr. A. B. Dancy, Jackson, Tenn.; Vice Presidents: Dr. Frank M. Acree, Greenville, Miss.; Dr. A. G. Harrison, Searcy, Ark.; and Dr. J. W. Oursler, Humboldt, Tenn.; Sec'y-Treasurer, Dr. A. F. Cooper, Memphis.

Dr. Dancy, the new president-elect, has lived in Jackson 45 years, and is an eye, ear, nose and throat specialist. He was graduated from Vanderbilt University in 1902 and has done graduate work at Harvard and in London, Paris and Vienna. He is a Fellow of the American College of Surgeons, and a member of the American Medical Association and of the American Academy of Opthalmology and Otolaryngology.—Commercial Appeal.

Surgical Dilemmas

BY DR. M. Q. EWING
Amory, Miss.

The occasion for this paper is simply my desire to bring out and emphasize a few of the many difficulties of surgical diagnosis and by case history illustration to bring out one or two points that I personally have found of value. Text books covering the diagnosis of surgical conditions are usually either so dogmatic or else so vague that the greater one's experience becomes, the more one is impressed with the fact that practically nothing is universally true in surgical diagnosis There occur exceptions to almost every established rule.

The following cases are illustrative of the unreliability of text book rules in certain cases of acute appendicitis.

Case 1. Miss Brown, age 19, a patient of Dr. T. D. Sumerford. Admitted with the following history. She had had in the past several attacks of abdominal pain with nausea treated under the diagnosis of Acute Indigestion by castor oil, with recovery. These attacks were not infrequently synchronous with menstruation but not always. Questioning disclosed that she had a "sore place" in the right ingual region for a few days subsequent to these attacks. The present attack began about thirty hours previous to admission with generalized abdominal pain of very severe character accompanied by nausea and vomiting. The pain remained excessive, not relieved by large doses (3-4 gr.) of morphine and the nausea and vomiting continued until admission to hospital.

Her temperature had been subnormal from the onset of attack and was 97^6 when taken at the hospital. She was a well-nourished, well-developed girl evidently in much pain and very nauseated. Physical examination was almost totally negative. The abdomen was not distended, not tender to pressure, and there was no rigidity. Pelvic examination was negative. She was midway between menstrual periods. Her urine was normal chemically and microscopically. Her leucocyte count was 6,200 with 88% polymorphonuclears. Her pulse, however, was 128 and she was evidently in severe pain.

Here was a case with a history resembling acute appendicitis, yet missing many of the criteria for a diagnosis. The leucocyte count is normal to low, and the important sign of rigidity of the Rt. Rectus is missing. There is no fever. There is no distention. The differential leucocyte count is not sufficiently high to be considered of importance by itself. Confronted by such a case text books are absolutely worthless and the surgeon must rely upon his own individual experience and a sort of sixth sense that practically all surgeons eventually develop to aid them in just such cases.

Something seemed to tell me that this girl was dangerously ill, far more ill than the physical findings and laboratory findings seemed to justify. We have all seen cases with almost identical history symptoms and physical findings and laboratory findings that turn out to be menstrual or ovarian colic, hysteria, or ureteral stricture. Yet something seemed to tell me that this was really appendicitis and probably gangrenous. Perhaps it was her pulse and the impression I had received that she was really ill. Perhaps it was the history of past attacks of indigestion followed by a "sore place" in the Rt. Inguinal Region.

In any event I advised operation, telling her parents that I was not certain of the diagnosis but that it might be a gangrenous appendix and that certain signs might be missing because of low resistance. I explained that I might have to close the abdomen after finding nothing wrong but that on the other hand, if it wêre appendicitis and perforation occurred with the evidence of low resistance she would certainly die. Her parents happened to be intelligent people and consented to operation which disclosed a swollen and distended totally gangrenous appendix that had to be handled with exceeding care to prevent rupturing it while removing it. The appendix was gangrenous clean into the base, the gangrene extending out over an area of the cecum that had to be inverted by pursestring for fear of cecal perforation. The patient made an uneventful recovery.

Case 2. Mrs. W. A., minister's wife, aged 36, a patient of Dr. W. N. Reed. Admitted to hospital with following history. She does not remember ever having been sick in thirty years. Had never had any digestive disturbance or colic of any kind. Menstrual history completely normal and menstruated without any pain or even discomfort. Present attack siezed about twenty four hours past with abdominal pain. There has been no nausea or vomiting. There has been no elevation of temperature. The pain has not localized except that it seems confined to the abdomen below the umbilicus but is as marked on the left as on the right.

Physical examination did not elicit any positive findings. The abdomen was flat, almost scaphoid. There was no distention. There was absolutely no rigidity, the abdominal muscles seemed unuusally relaxed for a nulliparous woman. There was only slight tenderness on deep pressure over the pelvis. Pelvic examination was totally negative. A catheter specimen of urine was normal and the leucocytes were 9,000 with 71% polymorphonuclears. But the patient kept complaining of sever abdominal pain unrelieved by a hypodermic of morphine.

Here was a case not typical of anything. Practically all physical and laboratory findings were negative particularly for appendicitis. My inclination was to wait and watch this patient and in another type of woman I would have acted accordingly. But here was a woman who had always been in the best of health and who described herself as "disgustingly healthy," and whose husband stated that he had never heard her even complain of even "feeling bad" before. There was not the slightest suggestion of the neurotic about her, and she kept complaining of severe abdominal pain and her pulse was 114.

Operation was advised under the pre-operative diagnosis of possible appendicitis. Operation disclosed a very long, very distended appendix full of pus with beginning gangrene of the last two inches of the appendix and a fibimous yellow membrane covering the proximal half of the appendix. The appendix hung over the pelvic brim and most of it was in the true pelvis. The appendix was removed followed by recovery complicated by a small stitch abscess.

Case 3. Miss Sudduth, age 17, a patient of Dr. I R. Burleson. Admitted with following history. She had always been well except for childhood diseases. Had never had any indigestion or abdominal complaints. Menstrual history completely normal. She awoke yesterday morning (30 hours past) feeling well but on attempting to dress found that movement caused a pain in the right side of her abdomen. She continued to eat and her bowels acted normally and she felt well but found that motion caused pain in her right abdomen. There had never been any pain or colic and so long as she remained quiet she was perfectly comfortable.

Examination disclosed an apparently healthy girl with normal temperature, pulse 80. The abdomen was not disturbed, but there was marked rigidity of the Rt. Rectus muscle with tenderness over the appendix. Other physical findings were negative. The urine was normal and the leucocyte count was 7,200 with 76% polymorphonuclears. There was of course sufficient evidence for a diagnosis of probable acute appendicitis and operation disclosed acute appendicitis, the appendix being tightly distended with pus. Recovery was uneventful. This case and the one following are submitted to show the bizarre symptomatology of this disease and the frequent unreliability of the laboratory findings in making a diagnosis.

Case 4. Mr. F. Millikan, age 22 a patient of Dr. M. S. White. Admitted with following history. Had had no previous abdominal complaint. Was siezed some 28 hours previous to admission with abdominal pain, nausea and vomiting. He had been given morphine with temporary relief of pain, but the nausea and vomiting continued. The pain had now localized in the Rt. Inguinal Region. He fortunately had not taken any purgatives.

His admission temperature was 102 F., pulse 118. His urine was normal. The leucocyte count was 16,200, with 93% polymorphonuclears. His abdomen was distended and tympanitic, with tenderness in Rt. Inguinal Region and spasm and rigidity of Rt. Rectus. The physical examination was otherwise negative. Operation disclosed an acute appendicitis with some free abdominal fluid and a small amount of pus and a large faecolitle in the appendix. The appendix was not nearly so inflamed as I had expected from the symptoms and laboratory findings.

Just what am I attempting to prove by these four cases? Chiefly that the diagnosis of acute appendicitis is frequently a difficult matter and that the physician who accepts the dogmatic teachings of some text books and waits for a classical picture is going to lose many patients from peritonitis. Second, that there are found not infrequently cases of acute appendicitis in which many or most of the expected findings are missing. Third, that the leucocyte count and differtial count in acute appendicitis can be most misleading. The blood changes are the result of the interaction of two opposing factors, namely the resistance of the individual against the viruleuce of the infection. The blood picture may fail to appear because the resistance is low or because the infection is overwhelming and it is particularly these cases that are likely to succumb if the appendix is allowed to perforate.

Just what should the surgeon do when confronted with this type of case? He should use all means at his command to make a proper diagnosis but in the end his action will depend upon his "surgical judgment" which is really the result of accumulated experience with similar cases. We all learn more from experience than we do from text books.

I next want to state a problem for which I have no answer and for which I earnestly desire one. This problem is illustrated by the following two cases:

Case 1. Miss McGowan, 17 years of age, a patient of Dr. W. A. Shelton. Was operated upon for acute appendicitis. The appendix was removed and the abdomen closed without drainage. Sixty hours after operation she began vomiting and there was violent peristalsis. The abdomen became distended and enemas after clearing the lower bowel returned clear without any gas. A diagnosis of mechanical obstruction by adhesions was made. The abdomen opened through a Rt. Rectus incision and a band of adhesions totally obstructing the intestine in the lower iluim severed. The abdomen was closed without drainage and an uncomplicated recovery ensued.

Case 2. Miss Mobley, age 19 years, a patient of Dr. R. L. Hill. Was operated upon for acute appendicitis. The abdomen was closed without drainage after removing appendix. This patient began vomiting about forty eight hours after operation. There was violent peristalsis washing stomach did not relieve the vomiting. Enemas after clearing the colon, became clear and returned without gas. The patient complained of violent abdominal pain and peristalsis was audible. The abdomen appeared moderately distended and was tympanitic.

Her abdomen was re-opened through a Rt. Rectus incision at the end of sixty-eight hours under the diagnosis of Intestinal obstruction probably due to adhesive bands. What was my surprise on opening the abdomen to find the intestines from the duodenum to the lower sigmoid contracted to a ribbon and undergoing visible and active peristalsis. There was a wide empty space between the anterior abdominal wall and the abdominal contents. There was no obstruction and no adhesions. I closed the abdomen and was still in a dilemma about what to do. I gave her large doses of atropine and began feeding her fruit juices as soon as she reacted from the anaesthetic. She only vomited once and from then on the convalescence was unusually quiet.

These two cases looked identical. One had obstruction. One had hyper-peristalsis. If it should occur again my action would be similar. I have as yet learned no method to distinguish the two.

I next wish to report two cases which illustrate a method of diagnosis which is not used frequently enough.

Case 1. Mr. Tom Davis 41, brother of the Supt. of Nurses of our hospital. This man had been an invalid for twelve years with a T. B. hip. He resided in Birmingham, Ala. While visiting his sister she asked me to examine him and I did so. He was a small man, very weak and emaciated. The examination was negative including blood and urine, except for his evident weakness and the area around the left hip. There were scars of sinuses that had healed and three draining sinuses. One was low on the buttock; one on the anterior surface of the thigh about three inches below Pourparts Ligament and the third was on the posterior surface of the thigh about midway between hip and knee. All these sinuses drained a thin watery pus. He stated that sometimes a sinus would heal but it would break out somewhere else in the vicinity in a few days. When one of these sinuses closed he would have fever for a few days. The whole area of left hip, buttock and thigh show scars of healed sinuses.

On examining this man I was impressed by the fact that while he walked with a slight limp there did not seem to be the amount of limitation of motion of the hip that one would expect from a T. B. hip of twelve years standing. I decided to X-Ray his hip and got a picture of an apparently normal hip. I was somewhat confused by this and decided to inject the sinuses with Sodium Bromide and re-X-Ray. When I did so the picture showed the sinuses did not come near the hip joint but extended upward entirely off the X-Ray film. I then placed the films higher and the pictures then showed the sinuses extending upward to the left kidney region to a mass of Renal Stones.

This finding was confusing in the presence of normal urinary findings. A cystoscopic examination showed the ureter on the right normal while the one on the left admitted a No. 6 F catheter less than two inches and no urine drained from this catheter. The left kidney was removed and after a stormy time the patient recovered and six months later wrote me that he had gained twenty-five pounds in weight and was at work.

Case 2. Mr. A. H. Spruill, age 29. A patient of Dr. I C. Buckelew. This man came to me for examination of his right hip, under diagnosis of T. B. hip. He had three draining sinuses on the posterior and lateral surface of the hip, which had been present for six months. He walked with a limp and could not fully extend the thigh without pain, which pain occurred in his sacro-iliac region rather than in the joint. Except for this there was no limitation of motion at all. Of course I doubted the diagnosis of T. B. hip. I took a flat plate of the hip which showed nothing abnormal. I then injected the sinuses with Sodium Bromide and took other plates. The sinuses extended not to the hip but to the crest and wing of the Rt. ilium. I advised operation under diagnosis of chronic osteomyelitis of Rt. ilium.

Operation disclosed extensive osteomyelitis of the Rt. Iliac crest with a large sequestrum which was removed, but also a foreign body, a piece of glass 3-4 inches long and 1-4 inch wide and 1-8 inch thick up against the sequestrum. This foreign body did not show in the film. On questioning the patient he stated that he cut his lip when thrown through the windshield of an automobile in a wreck and that he had considerable bleeding but the the wound healed and gave him no trouble. This two and a half years previous to the onset of trouble with the hip. The foreign body probably excited the osteomyelitis eventually. I am now a firm believer in the habit of injecting all draining sinuses and X-Raying them. They do not always lead to the point one thinks they come from.

Discussion of Dr. Ewing's Paper

Dr. Philpot: I had no idea just what Dr. Ewing's subject was meant to cover, but I have had some experiences similar to those he relates which turned out just opposite from his. When I operated I found a normal appendix after an obvious diagnosis of appendicitis. Only a few weeks ago, I diagnosed a case for appendicitis from symptoms which were fairly typical, but in going in I found a normal appendix. The patient went home and a few days later I had a call that she was having another attack. It certainly must have been pyelitis or an obstruction of the ureter.

I am very glad to have heard the reports of the foregoing doctors Haggard, McCown and Ewing.

Dr. Bryan: Once I had a severe pain following an abdominal operation. It was suggested that I had adhesions. But it occurred to me that I had spastic colon. And I think that is what I had. Soon it got better and I never have had a return. But I want atropine if it does.

Dr. McGehee, Memphis: I want to express my appreciation to the Thirteen County Medical Society for the kind invitation that I be present. It is indeed a pleasure to be here.

We who are constantly studying symptoms and symptom complexes can readily see the purpose and value of this kind of paper. Of course, there are exception to all rules, and the words always and never are out of place in the discussion of any Medical Society problems. You will not mind my reporting a case which I had a few days ago, which is analagous to those of Dr. Ewing. It was that of a young man twenty-eight years of age. He became ill with a sever abdominal pain about four o'clock in the afternoon, could find no position in which he could be at ease. His pain was most severe; a typical abdominal crisis. He was all doubled up when I first saw him, one and half hours after onset. Suddenly he became very quiet and still, maintained an immobile position, the least movement causing severe pain. He was in a cold sweat, temperature 96 degrees, pulse 120, leucocyte count 15,000, differential count 86% Polys, normal red cell count. He reported that he had never been sick, but we did get a history that for the last three years had had indigestion for which he had constantly taken soda. He also had a habit of consuming corn liquor constantly, about a pint a day, and on social occasions 2 pints in the course of an evening. On examination, when he was carried to the hospital, he had a board-like abdomen. One hour later his blood showed a leucocyte count of 18,000 and a differential of 93% Polys. On the strength of this, we opened the abdomen, expecting to find a perforated duodenal ulcer, and found none, a normal appendix, a normal stomach, a normal gall bladder, everything normal, except the liver was moderately enlarged, smooth, soft and a salmon pink color. We found nothing else. The appearance of the liver was most strange. I have never seen a liver like it. There were several surgeons present, of wide experience, and all agreed that such a liver was a "perfect stranger" to them. The outstanding feature was its salmon pink color. We decided, until a better name is supplied, we would call it a "Volstead Liver." This patient's post-operative course was uneventful, and devoid of any unusual symptoms. He was discharged on the 10th post-operative day.

Regarding Dr. Ewing's case No. it strikes me this is a case of angio-neurotic edema, with intestinal manifestations. I have seen two such cases which fit his description of the intestinal contraction with all the symptoms of acute intestinal obstruction. These cases, clinically intestinal obstruction, were found with small intestines contracted to cord-like structures and which upon, being touched or exposed to the air, immediately ballooned up and resumed the normal appearance. One of these cases subsequently to operation is always relieved by a full dose of atropine and is never without atropine tablets in his pocket, ready for the attack of pain. Dr. Ewing has given us a very interesting report; which warns us to "stop look and listen."

Dr. Lyle Motley: I have enjoyed Dr. Ewing's paper very much and it evidently is a timely one from the amount of discussion which it has aroused. However, all of the discussion has been from the surgical standpoint and nothing has been said about medical conditions which simulate surgical states. In the consideration of any acute abdominal symptoms coronary thrombosis must be thought of, particularly in males around middle age or past. This condition very frequently simulates an acute abdominal surgical condition as it presents epigastric pain of severe character, nausea and vomiting, rigidity of the abdominal wall, and very soon there appears a leukocytosis and small amount of fever. Just the other night I saw a patient who had been sent to the hospital with a very positive diagnosis of acute fulminating appendicitis, but whose condition was one of coronary thrombosis. He had the phenomena referred to and had not the surgeon to whom he was referred been a good doctor as well as a surgeon his abdomen would certainly have been opened with disastrous results.

Coronary thrombosis occurs in many different degrees of severity and character of manifestations and at times it is extremely difficult to decide on the exact condition present in a given patient when thrombosis is a possibility and particularly when the patient is known to have a chronically diseased gall bladder or appendix. However, there are one or two clinical points which are comforting to us when they are present. There is very frequently a marked drop in blood pressure out of proportion to that seen in any ordinary surgical condition and often there develops an irregularity in pulse. With these phenomena there very frequently occurs the characteristic heart sound which is somewhat "fetal" in character and often only one faint sound is heard. The signs of shock are also often present out of proportion to any other findings and the patient is obviously in a condition of collapse. The routine taking of blood pressure and careful observation of the circulatory apparatus in all cases past forty years of age presenting signs of acute abdominal accidents will help to pick out the occasional case of coronary thrombosis which is apparently a typical acute surgical condition. Of course in young people thrombosis does not have to be considered at all.

I always enjoy attending this Society more than most any that it is my pleasure to meet with and certainly appreciate the invitation to be with you.

Dr. John C. Culley: I would like to report briefly a case which will in a way answer Dr. Ewing in regard to the obstructions after operation.

This patient, a very fat man, had been operated on by me for intestinal obstruction which was partial, and caused by an acute appendix which had become adherent at the tip to the posterior wall of the pelvis at the brim, a loop of the intestines having slipped through the opening thus formed. On the fourth day he began vomiting, became distended, and had all the symptoms of another obstruction. I decided to operate and administered a spinal anesthesia. Before opening the abdomen I had an assistant to insert a large colon tube in the rectum and gradually pass it upward and withdraw it slightly at intervals. Within a few minutes liquid feces and gas began to pour through the tube and the abdomen became flat. The patient was returned to his room and made an uneventful recovery. I would advise spinal anesthesia in these cases before operation. If it is not one of true obstruction relief will be afforded.

Dentistry and Health

BY H. D. CHIPPS, D.D.S.
Corinth, Miss.

Honored by a request from the editor of "The Mississippi Doctor" to submit a paper for its pages from a dental viewpoint, without restriction as to subject, gives one a very wide latitude, as there is scarcely a single phase in the work and purpose of either profession that does not have some bearing on that of the other; for medicine and dentistry are not fundamentally separate professions, but rather branches of the same art and science, which has the common aim of the prevention and alleviation of human illness and suffering for those coming under our care.

The tremendous advancement in knowledge within the past few years is linking the two professions much closer together and has made it vitally necessary for the dentist to know something of medicine, and the physician, something of dentistry, in order to use good judgment in advice to, and the care of the health of the patient.

Dr. Charles H. Mayo makes the statement that, "the dentist who looks in the patient's mouth will miss something of vital importance to his patient if he sees only teeth in their capacity of masticating and aching, as will the physician who examines the patient for some local trouble, systemic condition, recurring disease or organic lesion, if he forgets the possibility of an oral cause for the disorder."

He also states that, "seventy per cent of human ills begin with disease in the mouth."

Of primary importance to both professions is the consideration of the effect that oral foci of infections have on the health of the individual, and on the subject there is almost complete accord.

Oral conditions likely to form sources of infection are: (1) Pyorrhea or periodontoclasia, (2) caries, (3) apical or periapical foci from pulpless teeth. The place that oral foci takes in relation to metastatic disease has been considered from the clinical, radiological, bacteriological, histo-pathological, and animal experimental standpoints; and much time, thought and energy have been expended in these investigations by such men as Rosenow, Billings, Daland, Haden, Hartzell, Price and many others of eminence in both professions, and the evidence is overwhelming that the constant absorption into the circulation, of toxic products from bacteria which are growing in areas of localized infection, will ultimately produe various disease entities, if not eliminated.

Oral foci and their toxins are proven etiological factors in such diseases as cholecystitis, acute appendicitis, ulcer of the stomach and duo-denum, acute and chronic arthritis, rheumatic fever, acute iritis, acute and chronic myositis, subacute bacterial endocarditis, skin diseases, neuroses, neuralgia and sciatica, sinus infection, and many others, as no part or organ of the body may escape, if the resistance of that part has been lowered.

The metastatic progress of bacterial toxins is by direct invasion of adjacent tissues; by passage along the mucous and serous surfaces of the alimentary tract; and through the blood and lymph channels, causing secondary foci in distant organs and parts of the body.

The virulence and amount of these toxins, and the general resistance or immunity of the patient, and the local resistance of the tissues attacked, have a great bearing upon the toxic effect produced, but by lowered resistance and loss of immunity through injury, age, malnutrition, over-work, pregnancy, influenza, and other factors, may render the patient with oral foci, liable to serious systemic disturbances, which other wise might be avoided if these foci were eliminated or prevented.

In a practical clinical experience of twenty-eight years, with a fairly large clientele, my observation has been that I have seen but very, very few patients that have any general impairment of health, that have had good teeth and a clean mouth. This indicates to me that the health of the mouth is a paramount factor in systemic health, and if the medical and dental professions could convince the people of this basic truth and the importance of caring for the teeth from infancy to old age, there would be a vast difference in the health of the human race.

Sir William Osler, the greatest European authority on internal medicine, said only a few years ago: "There is not one single thing in preventive medicine that equals mouth hygiene and the preservation of the teeth."

Dr. William T. Osborne, of Yale, says: "A dentist's decision may mean a long life or an early grave for his patient. A dentist's main problem is really not one of filling holes in teeth; or of restoring masticating surfaces; or of adorning the oral anatomy of his patients; but is one of life and death. Dentistry must be preventive, that is, built for the future. Dentistry has now been exalted to the highest rank in preventive medicine and it is for each member of the dental profession to decide whether or not he will live up to the new standard."

In the endeavor to deserve this high place in health preservation, intelligent and progressive dentists have almost completely scrapped old ideas and methods, which, in short, consisted of saving teeth, almost regardless of condition, by any manner of restoration that would conserve them as masticating units, without having a clear understanding that such conservation could have a detrimental systemic influence.

But in the light of present knowledge, the dental practitioner of today realizes the need of the application in his practice of the principle of prophylaxis and the revision of restoration methods, and is evolving a prophylactic dentistry.

This means that it is based upon a biological standard and is not limited to mechanics alone or solely confined to the oral cavity.

It means the total removal of all points of infection connected with the teeth and the elimination of types of dental restoration that are unsanitary; of the elimination of inflamed gums, abscessed teeth and pyorrhea. It means that by prophylactic efforts and preventive measures, to close the main portal of entry for disease germs and thereby answer the challenge of Dr. Chas. H. Mayo, when he said; "The next greatest step in medical progress in preventive medicine should be made by the dentists. The question is, will they do it?"

A great deal is being said about preventive dentistry now, and every effort is being made by the profession to really prevent dental defects by teaching the patient in the chair, by school examinations, through the press, and otherwise, to keep a clean, healthy mouth and to look after the teeth in time, and to control the diet.

But dentists are almost continually under the handicap of having to render service from six, twelve months, and even years past the time when it should have done, and for this reason, caries has often progressed so far that the vitality of the tooth is threatened or lost, or the health of the gingival and peridental tissues so destroyed that his best efforts at restoration are almost futile.

This procrastination on the part of the patient is primarily the cause for so much dental work that gets an undeserved credit of being poor dentistry, but which, regardless of dental skill, cannot possibly be more than a temporary staving off of the inevitable further decay, probable death of the pulp, and loss of the tooth.

No tooth filling, inlay, or other restoration can be better than its foundation, and if the patient has delayed until caries has penetrated throughout a greater part of the tooth structure, successful repair of a permanent nature is nearly impossible.

Usually, this delay is due to failure in comprehending the vital importance that prophylactic dental care and sound teeth have in safeguarding the health.

A timely word of advice and warning from their physician, upon whom they look as arbiter and counselor in matters of health, would go far to prevent much of this neglect.

Dental decay, primarily due to faulty diet, is extremely prevalent in childhood, and its immediate effects interfere with the ingestion and mastication of food. A child who swallows his food whole because of painful, abscessed, or decayed teeth is almost certain to suffer from disturbances of the digestion and possibly other defects of the constitution. It is reasonable to assume that the same conditions would prevail in the mature, when through missing teeth or the ravages of pyorrhea, the patient cannot properly masticate his food. Without thorough comminution by the act of chewing and complete softening by mixing with the saliva, the pre-digestion of food starches by the ptyalin is not begun in preparation for internal digestion, thereby lessening the nutritive effects of food, and depriving the system of some of the vitamin elements.

Malnutrition as a sequence of dental disorders is not only produced by lack of mastication by reason of a crippled dental equipment, but oral sepsis, with the ever present streptococci and staphylococci and other pathogenic organisms will produce gastro-intestinal effects, such as nausea, lack of appetite, bad taste in the mouth, furred tongue, gastric pain, feeling of emptiness in the stomach, belching of gas, flatulence, general malaise, and sallow complexion.

As dentistry concerns itself primarily with teeth, their preservation, restoration, and function; and as the health of the mouth is inseparably linked with general health and systemic metabolism, it naturally follows that dentistry should be interested in the main factor that promotes health and body growth; its nourishment.

The tremendous advance in knowledge during the past few years regarding the influence that the proper diet has in the preservation of health, and also the effect that proper dietary measures have in the control of caries and periodontal diseases has been proven by experiment and research, that the teeth and their supporting structures must receive the proper elements of nutrition to maintain their integrity.

This assuredly concerns the medical profession and we must look to the physician to advise and instruct his patients along this line.

Particularly is this true in the case of children and in pregnancy.

Pregnancy adds to the every day problem of dental decay, as dietary deficiency is made up to the growing fetus by inroads on its mother's tissues. The extra demand for calcium and phosphates, and an increased tendency to acidosis and anemia, affects the mouth secretions and the resistance of the gums, the increased acidity often causing extreme decalcification of the enamel of the teeth.

To combat this situation, the physician should give strict instructions and see that they are carried out, regarding a diet well balanced in respect to fats, carbohydrates, and proteins, and one high in all five vitamins and adequate in mineral content.

Such a diet would consist of milk, eggs, fruits, cereals and green vegetables, fish, or chicken, the red meats sparingly. Occasionally extra salts and vitamins may be needed, such as calcium, iron, iodine, and cod liver oil.

At all times there should be a spirit of co-operation between the physician and dentist, and at no time is it more necessary than during pregnancy when the welfare of the patient is to be considered.

The patient should be instructed to report to her dentist at the beginning, for examination, not only because of decay, but for elimination of any areas of infection in the mouth that might produce serious systemic complications during the term. Also the patient should report frequently for examination and prophylaxis, at least every six or eight weeks, as the condition of the mouth will usually indicate any dietary deficiency.

Pregnancy offers no barrier to proper dental care other than usual attention to elimination of pain, fear, and fatigue.

Is it not natural to assume that in all systemic irregularities, a clean alimentary canal, and beginning at the gateway of it, is more conducive to quick healing, than where a filthy mouth exists? This condition often confronts the physician in the bedside care of those confined for some period of time by fevers or other illness of slow character.

Comparatively few patients are so sick but for whom the improvement, relief, or elimination of unsanitary, painful, or septic conditions of the teeth and gums, will not add to their comfort, facilitate their general or specific treatment, or assist in their cure. Many patients will have a thick, fetid coating on the tongue, heavy, viscid saliva, and gummy deposits on the teeth. The tongue should be swabbed as often as necessary with peroxide of hydrogen, also a tongue scraper is advised. The edge of a small spoon is good for this purpose. The teeth should be cleaned with gauze swabs, cotton rolls, or tooth brush dipped in a good dentifrice, or lemon juice, or even weak vinegar, followed by rinsing with warm salt water. Once or twice a week, after drying as well as possible, the teeth and gums should be painted with a three per cent solution of iodine.

Care should also be observed after administration of strong medicaments that could decalcify the enamel of the teeth to neutralize by rinsing the mouth with a solution of bicarbonate or perborate of soda.

A little care along these lines during a protracted illness will do a great deal for the comfort of the patient and will undoubtedly go far to prevent much of the caries, decalcification, and oral infections that usually follow a period of lowered resistance.

As stated in the beginning of this paper, there is so much in the practice of medicine and dentistry that correlates, if the welfare of the patient is wholly considered, that, to that end, there should be a closer relationship between the physician and other specialists, and the dentist, for a better understanding of the problems that confront each other, and for the advancement of professional knowledge.

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Tinea of the Feet

BY ROBT. G. HENDERSON, M.D.
Memphis, Tenn.

Any discerning physician is fully aware of the fact that the medical profession is in ill repute with the general public, and the reason is not hard to find. Had we an authorized spokesman to present things medical to the lay men that they have a right to expect from us our just dues would be accorded us. The people generally concede that we are above the average in intelligence but they do not always credit us with common honesty nor frankness.

Witness an article from Holland's Magazine which I quote in part. "Modern practical medicine has strayed far from the Hippocratic Oath—so far as to cause many to pronounce the name of that grand old Code with a slight but eloquent difference. And if the profession would not be engulfed in the rising tide of public distrust, it will do well to dedicate itself seriously and anew to the most efficient service of mankind as its cardinal aim."

In the very matter which I wish to discuss with you, how many of us have been frank to the fullest with our patients? It is true that we disseminate the words athlete's foot, jockey stray itch etc., but do we tell the public that it is a fungus disease similar in all details with moss on a tree, dormant under adverse conditions but a verdant bay tree with heat and moisture? The first that we hear from our discussion is that every medical house in the country puts out a specific heralded to the profession; but strange to say very, very shortly in the hands of the layman without the intervention of the physician and all of the nostrums too strong. I believe that we Southern doctors are confronting a condition that most peculiarly effects the South.

I have been practicing medicine for more than a quarter of a century and any number of cases of eczema of the feet that I treated in the years past I am seeing today with a frank Tinea.

Northern and Eastern physicians are reporting their findings in groups of ten, fifteen or twenty five patients with Tinea of the feet whereas we Southerners are often times seeing that many in the course of the day. The causal organisms and the cultured characteristics of the growth under observation leads into such a maze that it is purely academic and intensely confusing.

I try to encompass all this with my patients by comparing the fungus to moss on the tree that needs heat and moisture for its prime growth but that can lay dormant for an indefinite time awaiting a propitious season. This question of dormancy is so imbued in my mind that I never give my consent to the use of shoes or slippers that have been used during an acute attack.

I also preach to a patient that a dry foot does not offer a favorable home for a fungus and for this patient after cure I prescribe the occasional use of a 25% Solution of Chloride of Aluminum as a drying agent. I have tried out every treatment that I have ever read or heard of and have reduced my proceedure to the simplest, for uncomplicated cases the old standby Whitfield's Salve at night, careful washing of the feet in the morning, then the cleansing with bathing spirits and then the use between the toes, in the stocking and the shoes of an antiseptic powder with some funguidal power. Personally, I use Boro-chloretone.

Most authorities advise a stronger per cent of Salicylic Acid than is found in Whitfield's Salve (3%).

If you have a heavy hide like skin through which vesicles are rupturing it would be unwise to expect an early cure till this dense epithelium was removed in which case a 30, 40 or 50% Salicylic Acid Ointment would be indicated. Bedridden patients with a Tinea and a super-imposed infection are not infrequent. Despite our fear of infection of the hands and feet on account of their complicated anatomy these infections rarely result fatally but they are extremely uncomfortable and a great economic loss. Again we have reduced their treatment to the simplest, namely a wet dressing of half strength Black Wash. I have seen many patients that seem to have a peculiar knack of having marked proneness to Tinea and yet I have never seen one where his general resistance as generally accepted had any bearing. One of the promising treatments of deep seated Tinea is vaccine but at present the reaction in some cases is so severe that it is going to take time to temper it. Some three years ago I saw a man with involvement of the soles of the feet that had existed for seven or eight years with marked thickening, formation of deep vesicles and profound itching. He had been given so much X-Ray and other conventional treatment that I had a vaccine made and which I administered in large doses with a perfect cure.

Knowing that our swimming pools, gymnasiums and all meeting places where the feet are bared are the places of infection it seems that our greatest obligation to the public lies in prevention and this is being subjected to most intensive laboratory study. I feel that the answer lies in Hyposulphite of Soda, an element strong enough in a weak solution to prevent infection but not strong enough in its greatest strength to effect a cure.

TO THE MEMBERS OF THE MEDICAL PROFESSION.

My attention has been called to an editorial which appeared several weeks ago in one of Mississippi's leading newspapers.

The editor of this particular paper has on many occasions used the expression, "Let us stick to the facts," in proving the error of his opponent's contention. In this editorial he failed to stick to the facts so far as figures are concerned and I feel it my duty to call attention to same. My only purpose in answering him now is to give the correct figures and state the true facts in regard to the subject to which he has called our attention. The purpose of his editorial was, in my opinion, well intended. It was timely. It was prompted by a desire, I am sure, to point to the members of our profession where we have been derelict in performing a duty, which is ours, and ours alone.

The very law which many of us are guilty of not observing is largely of our own making. Mississippi should be proud of the work of the State Board of Health. Especially should we take a pride in the Bureau of Vital Statistics. I doubt if there are many large corporations and few private individuals outside of our State, who, contemplating moving into the State, do not first seek valuable information from the Bureau of Vital Statistics. Foremost of importance is the birth and death rate.

To quote the editorial in question which appeared in the Jackson Daily News:

"Dr. Felix Underwood, state health officer, says there were nearly 9,000 births in Mississippi last year and one-sixth of the number were reported to the bureau of vital statistics from one to twelve month behind time. The same average will hold good on birth statistics for the first ten months of the current year.

"Commenting on this delinquency, Dr. Underwood offers some excellent reasons why all births should be promptly reported. Delays hamper the work of the bureau, belated reports are often filled with errors, and it is impossible to prepare an accurate annual report.

"It is up to papa and mama to poke up the family physician. Perhaps it would be a good idea not to pay the doctor's bill until he has furnished you with a copy of the birth certificate.

"Anyhow, try it out on the physician the next time a baby arrives in your family."

The facts, as shown in Dr. Underwood's report, are that there were 47,982 children born in Mississippi in 1930, and of this number between 8000 and 9000 were registered from one to twelve months late. Midwives deliver about 42 per cent of the babies while physicians deliver 58 per cent. Thus, it will be seen that the physicians are not wholly responsible for the late registrations. I am informed by the Bureau of Vital Statistics that the number of physicians and midwives failing to register births is about equally divided.

It is interesting to note that when the State Board of Health began its work with the midwives and the educational work among the mothers with reference to prenatal care, the mid-wives were delivering 52 per cent and the physicians 48 per cent. Thus, you see the educational work has been of direct benefit to the physicians, the mothers and the babies.

The editor, I am pleased to note, has a sense of humor and makes the suggestion that papa and mama not pay the doctor's bill until he has furnished them with a copy of the birth certificate. It would be interesting to know just how many of the bills for the above 47,982 deliveries have been paid, regardless of the birth certificates. If I were permitted to answer in the same vein, my suggestion would be for the physician to refuse the birth certificate until the bill was paid. However, that is not the point. There is no defence. We can only plead guilty to the charge of carelessness in a matter that is very vital to every child born in our state.

The fact that Mississippi's record in birth registrations is no worse than that of any other state is no excuse. The remedy is simple. If the registrations in all the other states are as poor as in Mississippi, now is the best time in the world for us to take the lead. We are in the beginning of a new year. Let us resolve right now that we will register every birth and death in 1932. Let us form the habit of doing the "proper thing at the proper time." We are all supplied with the proper blanks. While waiting for the arrival of the baby we have plenty of time to secure all the data necessary for the completion of the certificate with one exception the name of the baby. If the parents cannot decide on a name explain to them that the certificate will not be mailed until the first day of the following month. If they cannot give a name by that time the report is mailed in without one. We have done our duty and any further responsibility is theirs. A good reminder is to circle the first of each month on our office calendar and then have your secretary or office girl to remind us what the circle is for. That is what she is paid to do. Seriously, let us each do our duty toward every helpless infant born in our practice and register its birth promptly and properly, as the law requires.

This is not a complaint against the newspaper or the editor. I have reason to believe that the editor is friendly toward the medical profession. We, as physicians, are indebted to the newspapers of the state for their willingness at all times to give freely of their space for notices of our meetings and all matters pertaining to the public health. The layman never reads medical journals. He depends largely on the newspapers for his information and he usually believes what he reads in them. Thus, the newspaper is a great moulder of public opinion. This particular editor, while professing, and I believe he is sincere, friendship for the profession, frequently takes a back hand slap at us. He likewise uses the pitchfork on the lawyer, the banker, and the politician. But, this particular editorial is calculated to leave the public with the wrong impression.

We should be grateful for the criticism and look upon it as a constructive one. Often times our severest critics are our best friends. Personally, I am thankful for this editorial which calls to our attention a shortcoming which we can so easily correct.

JOHN C. CULLEY, President.

Program

The Southeastern Surgical Congress
Birmingham, Ala., March 7-8, 1932
Tutwiler Hotel

Monday

"Perfected Methods in Operations for Toxic Goiter" by Dr. W. D. Haggard, Nashville, Tenn.

"Cancer of the Larnyx" by Dr. Chevalier Jackson, Philadelphia, Pa.

"The Diagnosis of Surgical Affections of the Kidney and Ureter" by Dr. Edgar G. Ballenger, Atlanta, Ga.

"Technic and Clinical End—Results of Denervation of the Adrenal Glands" by Dr. George W. Crile, Cleveland, Ohio.

"Observations Drawn from 2,500 Thyroidectomized Cases with Special Reference to Hyperthyroidism" by Dr. Addison G. Brenizer, Charlotte, N. Y.

"Avertin Anesthesia" by Dr. George T. Tyler, Jr., Greenville, S. C.

"Diverticulitis and Diverticulosis" by Dr. John F. Erdmann, New York, N. Y.

"The Diagnosis and Treatment of Diaphragmatic Hernia, with Special Reference to Selective Treatment" by Dr. Carl A. Hedblom, Chicago, Ill.

"The Complicating Lesions of Appendicitis" by Dr. H. A. Royster, Raleigh, N. C.

"Central or Intracapsular Fractures of the Neck of the Femur" by Dr. Willis C. Campbell, Memphis ,Tenn.

"A Consideration of Newer Methods for the Prevention of Prostatic Hypertrophy" by Dr. Joseph F. McCarthy, New York, N. Y.

"The Differential Diagnosis of Bone Lesions" by Dr. Dean Lewis, Baltimore, Md.

Tuesday

"Diagnosis and Treatment of the Rectum and Rectosigmoid" by Dr. Fred W. Rankin, Rochester, Minn.

"Motion Picture Demonstration of Transurethral Correction of Prostate Gland Obstruction with Report of Results in Over 300 Cases" by Dr. T. M. Davis, Greenville, S. C.

"The Surgical Care of Infantile Paralysis" by Dr. E Laurence Scott, Birmingham, Ala.

"The Combined Medical and Surgical Management of Gastric and Duodenal Ulcer" by Dr. Frank H. Lahey, Boston, Mass.

"The Present Status of Gall Bladder and Duct Surgery" by Dr. R. L. Sanders, Memphis, Tenn.

"Surgery of the Ocular Appendages and Related Structures" by Dr. Vilray P. Blair, St. Louis, Mo.

"The Gynecologic Backwash of Obstetrics" by Dr. C. Jeff Miller, New Orleans, La.

"The Practical Treatment for Fractures of the Clavicle" by Dr. Frank H. Hagaman, Jackson, Miss.

"The Role of Neurology in the Field of Surgery" by Dr. Ralph Green, Jacksonville, Fla.

"The Operative Treatment of Carcinoma of the Recto-Sigmoid, with Methods for the Elimination of Colostomy" by Dr. W. Wayne Babcock, Philadelphia, Pa.

"Surgical Considerations in Undulant Fever" by Dr. Walter M. Simpson, Dayton, Ohio.

"The Decision Between Gastro-Enterostomy, Pyloroplasty and Gastric Resections Should Rest on a Pathological Basis" by Dr. Waltman Walters, Rochester, Minn.

The Uses of Iron in Medicine

BY EDWARD PODOLSKY, M.D.
Brooklyn, N. Y.

Metals are beginning to play a more and more significant role in therapeutics. Silver and its compounds, both organic and inorganic has found its proper place in the treatment of gonorrhea, gold and its salts has many advocates in the treatment of skin lesions, manganese, copper, iodine, and quite a few others are constantly being employed by physicians throughout the world. One of the most useful and one of the oldest in length of service to man is iron.

When iron was first used the reasons for its use were based on mysticism and empyricism; no scientific explanation was attempted for its indications. It was used in its crudest form, the person probably to have prescribed iron was Melampus the ancient Greek physician, whom his countrymen believed to have been the first mortal to have practiced healing. The form of iron he prescribed was rust. Later on physicians began to prescribe iron in the form of drinking water in which swords had rusted or water in which the "glowing iron is quenched in the smithies." A crude method but probably effective after a fashion, for it persisted for quite a length of time.

The earliest scientific evidence for the use of iron was the discovery by Menghinis in 1846, that iron was a normal and characteristic constituent of the blood. Menghinis also found that a diet rich in iron caused an increase in the iron content of the blood. In 1832, Foedisch found that patients suffering from what was then a rather common blood ailment, chlorosis, had a much lower content of iron in their blood

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than normal people. Ten years later Andral, Gavaret and Delafond found that when iron was fed to these patients suffering with chlorosis there was an increase in the number of red cells and a perceptible improvement in the patient's condition.

After these scientific contributions to the question of iron as a medicine there was much controversy, particularly during the years from 1890 to 1905 as to the absorption and utilization of different forms of iron, centering chiefly on food iron, complex organic compounds and inorganic iron salts.

With regard to food iron there can be no question as to its absorption and utilization. During the early growth period of man and animals in which there is a rapid development and extension of the various tissues, the hemoglobin increases satisfactorily on an adequate diet. Among the foods rich in iron spinach is recognized everywhere as one of the most valuable.

As regards inorganic iron the experimental work of such men as Macallum, Hall, Quincke and Gaule showed, by microscopic examination of the intestinal tract, that inorganic iron salts were absorbed mainly in the upper portions of the small intestines. Gaules also demonstrated the absorption of iron by admistering an 0.06% solution of ferric chloride by stomach tube and proving by chemical tests the presence of iron in the lympth of the thoracic duct three-quarters of an hour later. Additional evidence of the absorption of inorganic iron was obtained by Hoffmann and Rabe who used both man and animals as experimental subjects, and made quantitative comparative studies of the iron ingested and excreted.

Kunkel, Cloetta and Aberhalden proved by animal experiments that inorganic iron salts were absorbed, stored and subsequently utilized by the body for the formation of hemoglobin. The work of Tartakowsky confirmed the above findings and indicated that in addition to their ultilization for the formation of hemoglobin, inorganic iron salts had a pronounced stimulating effect upon the blood forming organs, especially when the hemoglobin was at a low level, as was found in chlorosis.

At the time when it was believed that the inorganic iron salts were not absorbed, various organic iron compounds were extensively used. With the definite knowledge that inorganic iron salts are absorbed and utilized for building hemoglobin, the use of iron organic iron compounds has been practically abandoned.

Since approximately 80% of the total iron content of the body is contained in the hemoglobin it is evident that during the growth period there is a great demand for iron to meet the rapid increase in hemoglobin formation. The usual food of man is not particularly rich in iron. Sherman in 1907, made an extensive study of iron metabolism and found that the average daily intake of iron was 11 to 19 mgs. In deficient diets or where the appetite is poor

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the iron intake may fall to as low as 4 mgs. The quantity of iron excreted in the urine and feces is almost equal to the intake. Studies made on two professional fasting subjects, Cetti and Breithaupt, showed a daily excretion in the feces of 7 and 8 mgs, respectively. It is, therefore, quite evident that under the most favorable dietary conditions the amount of iron derived from food is barely sufficient to cover our physiological demands: i.e., to provide for the catabolic losses, and does not allow any excess for iron, it would appear that this element has in large amounts a decidedly stimulating effect upon the blood forming organs and upon metabolic processes in other tissues.

Many different forms of iron have been used orally and hyperdermically for many years in the treatment of anemias. As a general rule, the results have been disappointing to both patient and physician. Recent clinical work, however, definitely shows that previous failures in the treatment of many of the cases of secondary anemia have been due in large measure to inadequate doses of iron. In 1926 Goodall advocated the use of large doses of iron in the treatment of secondary anemia. He regarded the massive doses of iron not so much a supply of iron but more as a stimulus to the utilization of iron, i.e., to the formation of certain substances necessary for the production of hemoglobin.

There are various forms of iron for oral and intravenous administration. Among the most commonly used are ferric oxide, ferrous carbonate and reduced iron, and these require an acid before they can be absorbed, and this is furnished by the free HCL which is normally present in the stomach. The disease in which iron is most often indicated of course are the anemias, primary and secondary, and quite often there is no free HCL in the stomach in patients suffering with these diseases. Consequently in these diseases the greater part of these water insoluble iron compounds are not absorbed. This point was emphasized by the negative results of Hart, Elvehjem, Wadell and Herrin using ordinary iron oxide, and by Doan, Sabin and Forkner using the magnetic ferric oxide prepared by Baudisch. Likewise, the experimental work of Mitchell and Schmidt indicates that the more soluble the iron salt and, therefore, the more available for absorption, the more pronounced is its therapeutic effect.

Many iron compounds such as ferric chloride and ferric sulphate exhibit a marked astringent effect upon the gastro-intestinal mucosa, and if repeated for a long period, strong astringents tend to impair gastric secretion and retard absorption. Of the iron compound, perhaps the most desirable from the therapeutic point of view is ferric ammonium citrate which possesses to a minimum any of the undesirable iron compounds.

Many physicians have been using iron and copper combinations in pernicious anemia with good results. This has been found to be a valuable reinforcement to the liver diet prescribed in this disease. Some benefit is always sure to be derived from some form of iron therapy in any of the blood diseases because iron is so important a constituent of the red blood corpuscle.

Iron has always been a symbol of strength, and from earliest times iron in some form has been the popular medicine for patients in a run-down condition. Preparations of hemoglobin with iron as a reinforcing agent has been popular in former times and is now becoming popular for poorly developed children and adults. The astringency of certain iron preparations is taken advantage of in the use of iron as throat gargle and as a styptic. As a local application it has been used in the form of Liq. Ferri Chlor. Fortis in painting the scalp in ringworm.

There is but little doubt that iron is one of the most valuable drugs in the materia medica.

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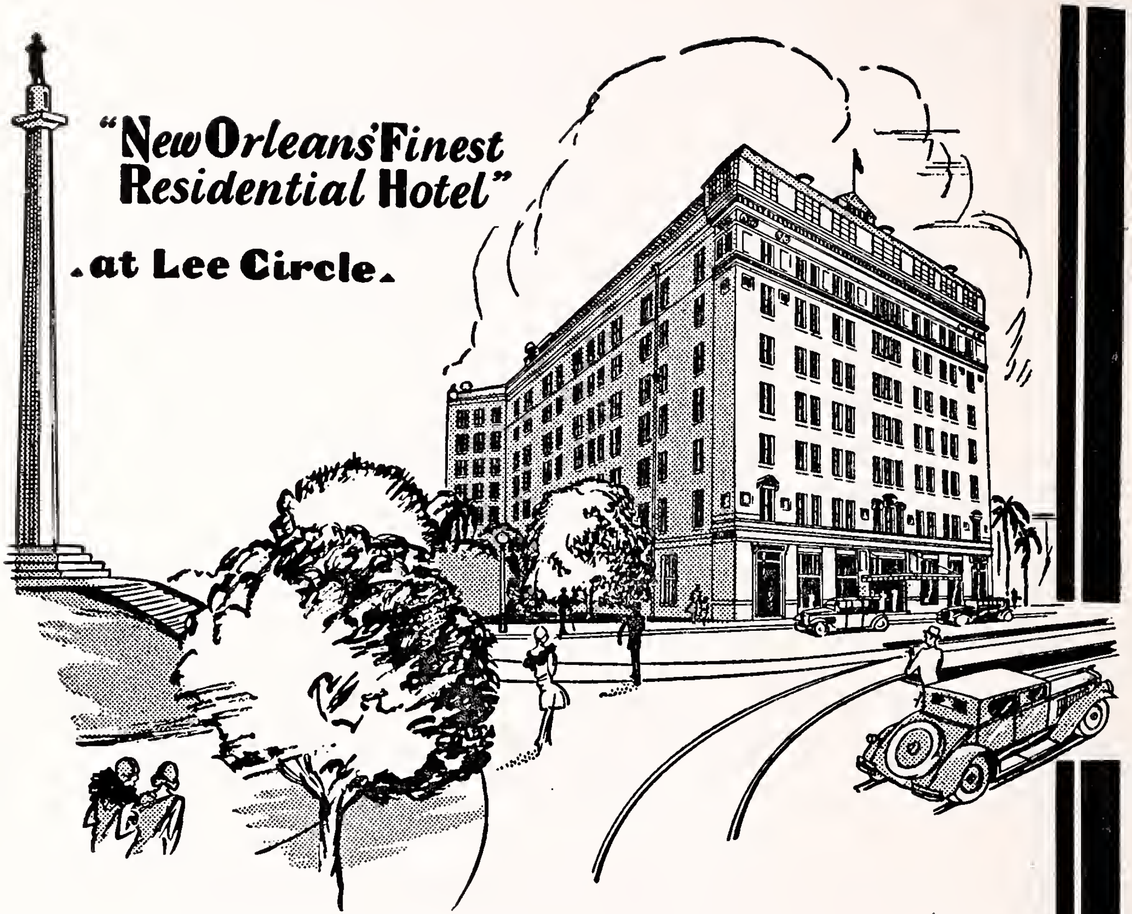
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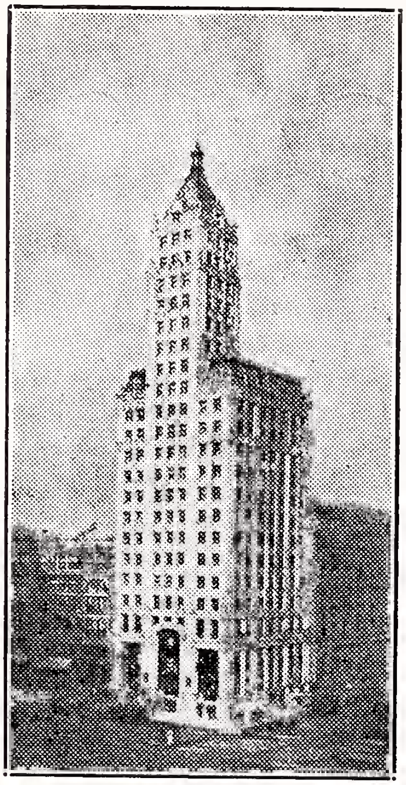

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Love Much

Love much. Earth has enough of bitter in it;
  Cast sweets into its cup whene'er you can.
No heart so hard, but love at last may win it.
  Love is the grand primeval cause of man,
  All hate is foreign to the first great plan.

Love much. Your heart will be led out to slaughter,
  On altars built of envy and deceit,
Love on, love on, 'tis bread upon the water;
  It shall be cast in loaves yet at your feet,
  Unleavened manna, most divinely sweet.

Love much. Your faith will be dethroned and shaken,
  Your trust betrayed by many a fair, false lure,
Remount your faith, and let new trusts awaken.
  Though clouds obscure them, yet the stars are pure;
  Love is a vital force and must endure.

Love much. Men's souls contract with cold suspicion;
  Shine on them with warm love, and they expand.
'Tis love, not creeds, that from a low condition
  Leads mankind up to heights supreme and grand.
  Oh, that the world could see and understand!

  Love much. There is no waste in freely giving;
  More blessed is it even than to receive.
He who loves much, alone finds life worth living.
  Love on, through doubt and darkness; and believe
  There is no thing which Love may not achieve.

—Ella Wheeler Wilcox.

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Statement of Condition as of December 31st, 1931—Third Year

Resources (Assets):

Bonds: State, County and Municipal bonds only (no industrial bonds), under which the company has received all interest payments due during the year. There is no principal in default	$ 753,933.49
First Mortgages: On improved city real estate only—(the company owns no farm mortgages and has foreclosed no mortgage loan)	181,654.88
Policy Liens and Deferred Premiums: Renewal premium notes, $17,635.61; policy loans, $8,327.18; net deferred and uncollected premiums, $100,982.90	126,945.69
Cash: The company has no cash in any closed bank, owns no certificate of deposit and has made no time deposits. All of its cash in bank is withdrawable on demand. The amount of this item, including $286.75 in the company's office is	46,808.75
Accrued Interest: Adequately secured by bonds mortgages, policy loans, etc.	9,192.45
Real Estate: The company owns no real estate acquired under foreclosure or otherwise	None
Miscellaneous Assets: The company takes no credit for its current agents balances and makes no advances to its agents. It has no stock notes, or collateral loans. It takes credit for no securities other than those given above. It takes no credit for its equipment inventory	None
TOTAL RESOURCES	$1,118,535.26

Reserves (Liabilities):

Reserves: For policies of insurance, as computed by the Actuary of the Bureau of Insurance of the State of Alabama, and covered by securities approved by the Superintendent of the Bureau of Insurance and held by the Treasurer of the State of Alabama under the Compulsory Reserve Deposit Law of the State, $206,491.00, less reinsurance reserves, $25,205.00,—$181,286.00; Reserves to cover other policy obligations, $1,786.00; death claims in process of settlement, $6,000.00; borrowed money, being part of purchase price of business of another company, $157,290.00; excess of liens over reserves, $529.05; present value of installments payable under disability claims, $10,789.24; present value of installments payable under contracts not involving life contingencies, $1,881.09		$ 359,561.38
Reserves: To cover agency obligations, $1,666.89; accrued expenses and taxes not yet due, $5,274.03; premiums and interest paid in advance, $505.82		7,446.74
Reserves: Contingency funds held to cover market value of bonds (National Convention of Insurance Commissioners values)		11,858.49
Capital Stock	$458,090.00	
Unassigned Funds	281,578.65	
General Surplus for Protection of Policyholders		739,668.65
TOTAL		$1,118,535.26

	Policies	
Life Insurance in force (life only)	7938	$21,179,950.00
Additional Accident Ins. (not including double indem.)	1052	2,736,039.00

The company has preferred not to do a reinsurance business and accepts no reinsurance from any other company.

The company offers all standard forms of life insurance and endownment issuance and annuities, including institutional endowments, children's educational endowments, old age pension funds, group, wholesale and salary savings insurance, group insurance under employee-employer relationships, etc.

Some Gains of 1931:

Insurance in Force (11.1%)	$2,103,201.00
Net Resources (13.0%)	110,889.13
Surplus Resources (7.9%)	21,341.21

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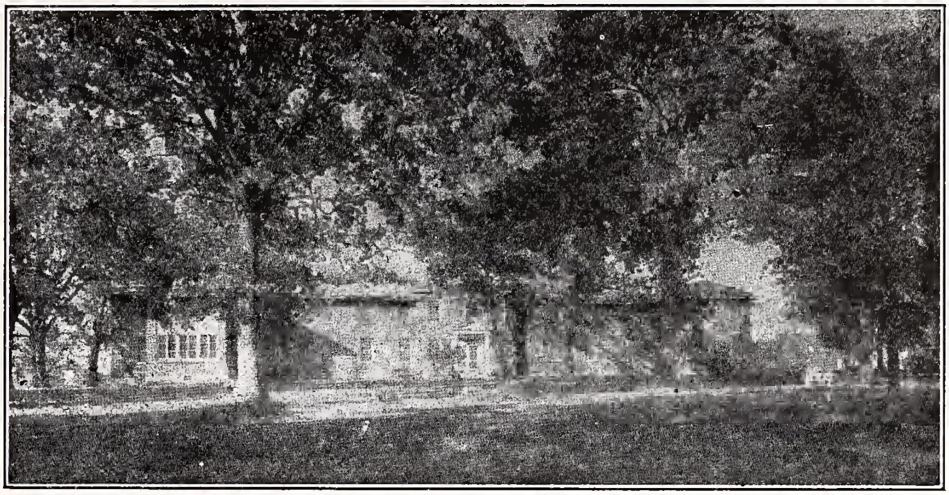

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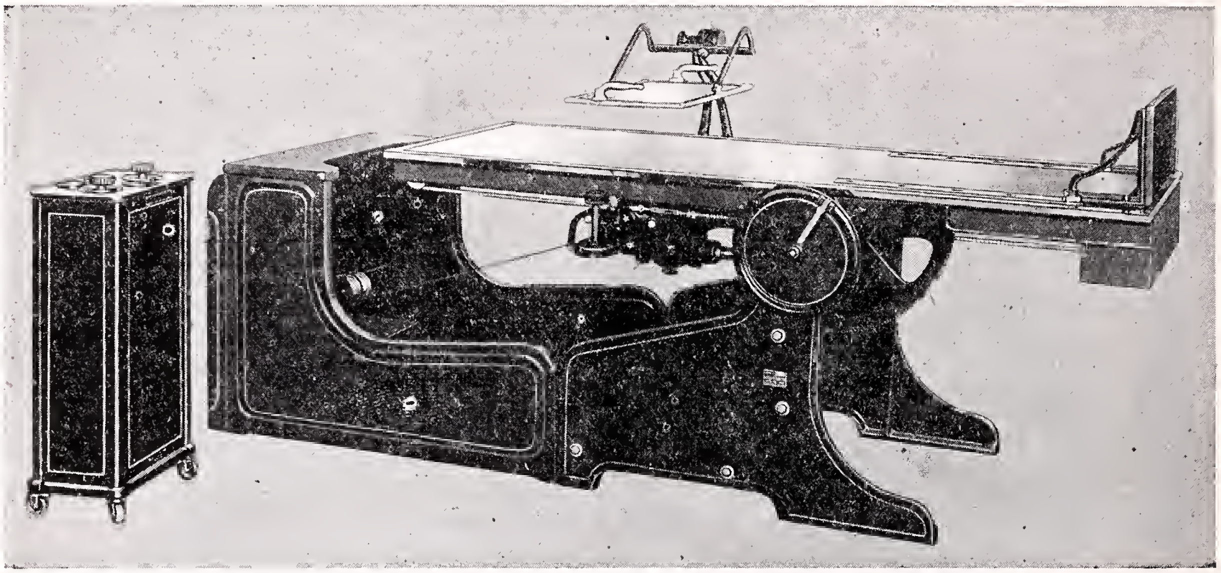

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NORTH MISSISSIPPI 6-COUNTY MEDICAL SOCIETY

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Entered as second-class matter, January 18, 1926, at the post-office at Booneville, Miss., under the Act of March 3, 1879.

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We had a splendid scientific program at the meeting at Booneville on March the 15th. Every essayiest was right there on time with a good paper. The discussions were free. We had a fine bunch of visitors from Memphis and from the North Miss. Seven County Society. We were mighty glad to have all of them. Dr. J. C. Culley, President of the State Medical Association, was president and made an interesting talk at the banquet. Dr. Culley has made a most active president. The State Association should appreciate his services. His contact with the societies of the state has been very helpful. He has in this way helped to distribute helpful ideas from one to the other. He has carried to them helpful information and inspiration and has received the same from them in return. Dr. Culley has traveled over five thousand miles and spent more than fifteen hundred dollars in his efforts to make a "good president". I doubt if ever before we have had a president who has been so active. We are sure that his efforts are appreciated. Dr. Felix J. Underwood was president and greeted his old friends. Dean Mull was with us with three of his popular students. He told us of our medical school at Ole Miss and convinced his hearers that his heart, mind and soul are in the work. Vice president Speck made an interesting talk at the banquet urging the importance of members paying their dues and being active members of their local and state societies. Dr. V. B. Philpot gave a fine report of the work being done by the hospital committee that has for its aim the fair distribution of charity funds to the hospitals of the state.

The American Medical Association will meet in New Orleans this year, May 9-13. You will find in this issue of the journal a program of the Woman's Auxiliary. Mrs. S. M. Blackshear is chairman of the publicity committee.

We appreciate the ad from the Peabody Hotel, "The South's Finest and one of America's Best", and the one in which we all feel a pride. The Tennessee State Medical Association meets in Memphis in April 12, 13, 14. The proctological society will hold its session in Memphis in May. You can't beat the Peabody.

There will be a luncheon for the surgical section at the Edwards Hotel on second floor at twelve o'clock Wednesday, April 13th. You will have a fine feed for seventy five cents and you will hear some interesting addresses. Drs. Haggard, Dabney, and Sanders will be among the ones who will talk to you and answer any questions in which you may be interested. Remember the place and remember the time.

Pay your medical dues if at all possible. It will do you good in more than one way.

You will note the review of the Matas Birthday Volume published by Paul B. Hoeber, Inc. New York. You will certainly want this book. Dr. Matas is well known around the medical world. He has the professional mind, the medical soul and the missionary heart. He is one of the most versatile men in the entire world. It is doubtful if ever another man has been able to hold as much dependable knowledge at the end of his tongue as does Dr. Rudolph Matas. He loves the science of medicine and surgery. He is gigantic in intellect. He has always been a profound student. His sympathy for his fellow man, for the sick person, are as deep as the ocean. Every person who loves the science and the practice of medicine and who knows how to estimate the value of a contact with a medical personality who holds his head far above the clouds, will want a copy of this book. J. A. Majors Book Company, New Orleans, or Dallas will secure this book for you when you are down at the A. M. A. if you like.

We doubt if there is a state in the South that has bigger public health problems. It is a state of rural population and small towns. It has no large cities. Its fifty two percent negro population has made tuberculosis a major problem in our state, as more than three negroes die of tuberculosis to one white person. Malaria claimed its victims by the hundreds and the thousands until our public health department did such fine work. We have had a state heavily infected with hookworms. Typhoid fever claimed a heavy toll. But our state has marched to the front in public health. Typhoid has all but been exterminated comparatively speaking. Malaria and hookworm infection have been placed in the back ground. The death rate from Tuberculosis has been reduced about fifty per cent in recent years. Think of all the work our state board of health has done and compare the funds at their disposal with other states and surely your heart will beat with gratitude and your voice will sing the praises of our public health department. For public health work: Alabama, $640,818, Tennessee, $383,070, Georgia, $494,970, Louisiana, $406,000, South Carolina $334,544, Mississippi $195,000. Northern and Eastern States, New York, $2,682,878; Pennsylvania, $2,633,250; Massachusetts, $2,798,385; Illinois, $1,319,722. We should not waste one penny on public health, but we should invest every dime we can. It pays big dividends. Sickness is very costly. Good health is an individual's greatest asset. Our state's greatest wealth is its healthy man power.

Dr. G. S. Bryan delivered a fine discourse on osteomyelitis. It elicited much discussion and brought out the essentials on this important subject.

The Mississippi State Medical Association will meet in Jackson at the Robert E. Lee Hotel, April 12, 13, 14. Do your best to attend this meeting. It will do you good. You owe it to yourself and your clientele to attend your local society and your state association. A splendid program awaits you. Our capital city is a delightful place in which to hold a meeting. Do your duty to organized medicine. Attend your state medical society.

We were delighted to have Dr. J. S. McCowan of Memphis attend our local society at its meeting in Booneville. He is a Mississippian. He keeps up interest in our state. He is an ardent believer in the community hospital, in its big possibilities for service to the country folk.

The small town offers greater opportunities for the practitioner of the future than does the city. Don't forget this. The city has one physician to about four hundred and fifty population. Mississippi has one to about fifteen hundred.

The decentralization of the medical profession is of the greatest importance.

If the state will take care of the actual charity in the small hospital the question of the high cost of medical care will soon be solved.

Modern medicine is even now on its march to the country.

In the multitude of consultations of specialists there is great danger.

We are delighted to have a news department from the Medics at Ole Miss. It is in charge of W. B. Beacham Jr., the brilliant and fine son of Dr. Beacham of Hattiesburg. He will do this well. You will enjoy his news department.

We are delighted to have a fine paper from Dr. Edley Jones of Vicksburg over on the Father of Waters. He always writes a good paper. This one is on a subject that should be of interest to every practitioner. We thank you Dr. Jones.

You will read with interest and profit the splendid paper in this issue by Dr. Staton of Columbus.

We appreciate the renewal of the ad for the William Len Hotel, "The Popular Hotel with the Popular Price", the one succeeding by success.

Our state medical association meets in Jackson on April 12-14. Make ready to attend your state association. It will help you. If it can not then you are duty bound to help it. Your local and your state societies should come first.

No man can give a sound, sensible reason why the small hospital should not have charity funds for its unfortunate sick.

Economically speaking rheumatism is perhaps our favorite disease. Like the poor, every one almost, has it sooner or later. Its favorite habitat is the northern states.

The Medical Mentor has a big field for service. It is not all of medicine to know the therapeutics of a pill and the detailed insertion of a muscle.

If you want to be useful in the medical profession, use your God given powers of observation. Open your eyes and see, your ears and hear what medical science is showing and telling you. Medical research needs the observing eye and the attuned ear of the country practitioner to speed its pace with accuracy and practicality.

We have had group life insurance carried by the State Medical Association for several years. It is mighty cheap, protection. We appreciate it very much. We hope the association will continue to carry it. Following up this idea we urged the state to endorse a group liability insurance which it did. It will be a wonderful saving if the physicians take advantage of it. Not only this, but in our opinion it will be better than what we have had. The contract will be with the United States Fidelity and Guaranty Company. The practising physician, especially the surgeon, can ill afford to be without liability insurance. Each year it is more imperative that he have it. This is your opportunity. Group insurance saves us money and it develops the spirit of co-operation. See your agent and take out your liability insurance.

The medical department at Ole Miss must be saved and it must be made better and stronger. It has rendered too much service to be given up. We know that the Board of Trustees of State Schools will look after its interests. We believe the legislature will do all it can for the school under the circumstances. The requirements of the Medical Council should be reasonable such that we can meet at this time. There is a tendency to place too much importance on a mere piece of laboratory equipment. Ole Miss has done the work. It has the medical spirit. We love the school. We are going to stand by it. It must live, and grow and go forward.

We have a few doctors in the state who are climbing mountains every day in their fears of state medicine. The mountains are imaginary at present. We need never get to them if the medical profession give the people, the general public, the masses, good medical and surgical servic at a reasonable cost. The development of the small hospital with the state paying for the actual charity and no investment in the institution nor its equipment, will prove a great help in indefinitely postponing state medicine. We have a few physicians who seem to be trying to throw a wrench in the cogs of our public health department claiming that it is a hair's breadth from the path of rectitude and right in receiving funds according to the "all wise medical ethics expert." There is no one thing that will do more to keep us out of state medicine than legitimate public health work. Now is the time to stand by your hospital committee and get a fair distribution of funds throughout the state. In this time of stress and strain you need to stand by your state board of health and uphold its hands.

One of the most important pieces of legislation coming before our law making body is the proper distribution of charity funds to our indigent sick. The state of Mississippi is supporting five charity hospitals, at a cost of about one quarter of a million dollars annually in addition to the investment in the buildings with their equipment and their up keep. All other states own and operate only three. The five charity hospitals are in the central and southern part of the state, namely Meridian, Jackson, Vicksburg, Natchez, and Laurel. It is not practical for more than one third of the population of the state to utilize the benefits offered by these hospitals. The entire population of the state pays taxes for hospital benefits. There was a time when the state hospitals served well and supplied a great need. Private funds, church and philanthropy have now multiplied hospitals throughout the state until at this time they have a thousand idle beds, quite enough to take care of all the charity for which the state is able to pay.

The time is propitious and justice and economy are demanding that the funds provided by the state for the indigent sick be distributed equally to every county according to its population. No lump sum should be given to any hospital. Every hospital approved by a committee composed of a representative of the Mississippi Hospital Association, the Mississippi State Medical and Nurses' Association should be eligible to receive charity patients at three dollars per day with small fees for other necessary services. The patient should be allowed to go to any hospital in the state that he prefers, but let the account be charged against his county. Care should be taken to admit deserving charity only. Each account should be approved by a local board of trustees before it is paid by the state treasurer. This plan will enable the state to sell the state hospitals it has and use these funds for other purposes. It will relieve the state of a large investment. It will give the people better service at home at less cost. It will do away with five big "political foot balls." It will enable many small hospitals to live and serve the great middle class of people at a reasonable cost. It will enable the profession to have small medical centers in every one to three counties in the state. It will be the big means by which modern medicine can be carried to the country folk who have paid taxes all these years but who have not received any benefit directly. The development of the small hospitals throughout the country will be a big factor in decentralizing the medical profession, in carrying modern medicine to the people out at the cross roads and down by the mill. It will cause the medical profession to start a march from the over crowded cities to the country that is in dire need of better medical and surgical service. This move will be a big boon to preventive medicine and preventive surgery. The equal and fair distribution of charity funds for our unfortunate sick offers the greatest returns that may be obtained at this time for the same amount of money.

We have faith in our law making body. They are in earnest. From the standjoint of economy, in the name of human suffering, for the promotion of scientific medicine, and for the love of justice, of common sense and unanswerable reason, they will carry this service back home with them to their people.—The Booneville Independent.

Woman's Auxiliary to the American Medical Association

Tenth Annual Meeting

New Orleans—May 9-13, 1932

Headquarters: Jerusalem Temple, 1137 St. Charles Ave.

All Women attending this Convention are invited to participate in entire program whether they are members of the Auxiliary or not.

PRELIMINARY PROGRAM

Monday, May 9, 1932

6:00 P. M. National Board Dinner and Pre-Convention Meeting (for Board Members, only) .... Orleans Club, 5005 St. Charles Ave.
Tickets $1.50

Tuesday, May 10, 1932

9:00 A. M. General Meeting .... Jerusalem Temple
Mrs. Arthur B. McGlothlan, presiding
12:30 P. M. Buffet Luncheon .... Jerusalem Temple
Tickets $1.00
2:00 P. M. Walk through Vieux Carre, with Guides—Starting from the Patio Royale.
4:00 P. M. Tea .... Patio Royale
8:00 P. M. General Meeting of the American Medical Association—Auditorium.
10:00 P. M. Reception and dance in honor of the Woman's Auxiliary .... Tip Top Inn, Roosevelt Hotel
Hosts: Orleans Parish Medical Society

Wednesday, May 11, 1932

9:00 A. M. General Meeting .... Jerusalem Temple
Mrs. Arthur B. McGlothlan, presiding
12:30 P. M. *Auxiliary Luncheon .... Southern Yatch Club
(12 minutes from Canal Street or Jerusalem Temple. Luncheon tickets, $1.50, Transportation, 25 cents.)
2:30 P. M. Post-Convention Board Meeting .... Southern Yatch Club
2:30 P. M. *Through Garden Gates; Glimpses of New Orleans.
4:00 P. M. Teas in Private Residence.
New Orleans Country Club
8:30 P. M. to 12:00 P. M.

Divertissements in the Garden, under the direction of Mrs. Lillian Lewis.

Buffet Supper.

Negro Spirituals—Courtesy of the Woman's Auxiliary to the Louisiana State Medical Society.

Thursday, May 12, 1932

9:00 A. M. General Meeting .... Jerusalem Temple
Mrs. Walter Jackson Freeman, presiding
10:00 to 10:15 Special Round Table Conference .... Jerusalem Temple
12:00 M. Buffet Luncheon .... Jerusalem Temple
Tickets $1.00
1:00 P. M. *Trip to Oak Alley Plantation; visiting Spillway. Returning at 6 P. M. (Round trip, $2 per person) or
2:00 P. M. *Round-trip over Lake Pontchartrain, via New Bridges ($2 per person) or
2:30 P. M. *Trip to Versailles Plantation, Battle Field of New Orleans; Docks and Wharves (Trip $1 per person) or
2:30 P. M. *Delgado Museum and City Park; Newcomb Art School and Audubon Park (Trip $1 per person) or
2:30 P. M. *Mayan Exhibit .... Tulane University
9:00 P. M. President's Reception and Ball .... Auditorium

Friday, May 13, 1932

9:00 A. M. *Trip to Gulf Coast—Train leaves L. & N. at 9 A. M. returning to New Orleans at 6 P. M. (Round trip, $5.25 including luncheon at Great Southern Hotel in Gulfport, Miss., and bus transportation along the coast.)
10:00 A. M. Golf Tournament .... Metairie Golf Club

*All trips start from Jerusalem Temple. Bus transportation to be paid by Individuals.

Mrs. Joseph Hume, General Chairman.
Mrs. Joseph Menenlez, Chairman of Hotel Committee

Ocular Manifestations of Syphilis

BY EDLEY H. JONES, M. D.
Vicksburg, Miss.

Unless one stops to consider the subject, one does not realize how many and varied are the ocular manifestations of syphilis. Inasmuch as this paper is presented before a group primarily interested in general practice, these conditions will be discussed more from the viewpoint of the general practitioner than that of the oculist. The discussion will follow an anatomical outline in preference to the type or stage of the disease. Suggestions as to treatment will be limited to the local condition; Dr. Weston will discuss the general treatment in his paper.

I. Lessions of the Orbit, lids and adnexae.

A. Periostitis.

Syphilitic periostitis usually involves the orbital margins but may involve the walls, particularly the superior or outer ones. It is usual gummatous in type and causes trigeminal neuralgia, worse at night. Mobility of the eye may be affected, with development of diplopia (double vision) and squint (crossed eyes). The margins may be involved by the sclerosing type, causing narrowing of the orbit with resultant exophthalmos. Tenderness is noted on pressing the eyeball backward and there may or may not be swelling of the lids. Only constitutional treatment is indicated.

B. Lesions involving the eye lids and conjunctiva.

Syphilitic lesions of the lids may be either primary, secondary or hereditary.

Chancres are usually located at the inner canthus, involving both lids and the conjunctiva. The mode of infection may be by kissing or by the rather filthy, and fortunately uncommon, practice of attempting to remove foreign bodies with the tip of the tongue. The lesion usually starts as a pimple and gradually develops into a saucer-shaped ulceration with rounded edges and an indurated base. The treatment is constitutional but yellow oxide of mercury ointment may be used locally, provided the patient is not given iodides. In that case, some other form of mercury, sterile vaseline or butyn ointment will suffice.

Secondary syphilids and gummas may occur on the eye lids and require no special mention; Dr. Akin will discuss that phase of the disease.

In cases of hereditary syphilis a popular eruption may appear on the lids shortly after birth or a blepharitis may develop. This blepharitis is characterized by small ulcerated areas on the edge of the lids and falling out of the eye lashes. This condition has been recorded in cases of acquired syphilis but is usually due to the hereditary type.

"Rhagades" or skin cracks at the external canthi, analogous to those at the corners of the mouth, have been noted both in congenital cases and as secondary manifestations in acquired cases.

As mentioned above, chancres may involve the conjunctiva; so also may secondary ulcerated papular syphilids and mucous patches; gummas of the conjunctiva have been reported. These lesions usually arise from the acquired type but papular syphilids and gummas have been reported due to the hereditary type.

There is also a true syphilitic conjunctivitis appearing either as a stubborn catarrhal inflammation or as a granular conjunctivitis, found in both the acquired and hereditary types.

The treatment for all these conditions is constitutional but a mild mercury ointment is beneficial when applied locally.

C. Ocular Paralyses.

According to Alexander 59.4 per cent of the cases of external ocular muscle paralyses are syphilitic. The lesion may be inflammatory or gummatous and may occur at any site on the paths from the central nuclei of the brain to their entrance in the orbit. The oculomotor nerve is the most frequently involved; next the abducens and least frequently the trochlear. This condition is very rarely the result of hereditary syphilis, usually developing as a late manifestation of acquired syphilis. The treatment is constitutional and the prognosis depends entirely on the state of the disease.

D. Syphilis of the Lacrimal Gland.

The lacrimal gland is very rarely involved by syphilis, but true syphilitic dacry-adenitis has been described. The usual anti-syphilitic treatment is required.

II. Lesions of the Eye Ball.

A. Tunical Sclerosa.

1. Cornea.

Perhaps the best known and most frequently recognized syphilitic condition of the eye is interstitial, or parenchymatous keratitis. Approximately 90 per cent of these cases are syphilitic in origin. It is usually due to the hereditary type but about 10 per cent of cases are due to the acquired type. Occasionally it is the result of trauma to the eye of a syphilitic individual.

As the name would indicate, the lesion affects the substance of the cornea. They may first appear either centrally or at the periphery and are small opacities surrounded by a haze. In a few days the whole cornea appears steamy. Pericorneal injection is usually present. The patient complains of loss of vision photophobia and lacrimation. If the condition is complicated by iritis, pain is usually present. Both eyes are usually affected.

Approximately 50 per cent of cases are complicated by iritis. Descemetitis (inflammation of the posterior surface of the cornea) and hypopyon (formation of pus in the anterior chamber) are not uncommon. Anterior synechiae may form. Corneal ulceration is rare. Retinitis and choroiditis are fairly frequent complications. Myopia, secondary glaucoma, and irregular astigmatism of high degree are sometimes sequels of this condition.

In my experience the best local treatment consists of atropine, hot boric acid bathing and a bland antiseptic eye wash. The tension must be carefully watched. Occasionally it will become increased; atropine must then be discontinued and eserin substituted; paracentesis may be indicated. Dionin in 5 to 10 per cent solution is a valuable adjunct. Smoked glasses must be used, or the patient must be confined to a dark room.

Hypopyon, when present is relieved by paracentesis, repeated as often as necessary. Pain may be relieved by codein and acetidine. Arlt's salve (12½ percent Tinct. Belladona in Mercury Ointment) applied over the forehead and temple may be more efficient than codein.

There is another form of keratitis, known as keratitis punctata syphilitica, which is characterized by small greyish spots in the cornea, without the generalized haziness or episcleral injection. The treatment is the same as outlined above for interstitial keratitis, but the prognosis is much better.

2. Sclera.

Syphilitic scleritis is quite rare and is due to the hereditary type. It sometimes complicates interstitial keratitis. It does not respond to any local treatment but usually clears up quickly when treated constitutionally.

B. Tunica Vascularis.

1. Iris.

This organ is more frequently involved by syphilis than any other portion of the eye, and is perhaps more closely noticed by those in general practice. The Argyll Robertson pupil and its significance is well known. In this condition the pupils do not react to light, but do react to accommodation. The condition is usually bilateral. The pupils are usually miotic (smaller than normal) and may not be of the same size; the pupils may be oval or pointed in shape.

Iridoplegia, a condition where the pupils are fixed and do not react to any stimulus, is usually syphilitic.

Iritis is the most common syphilitic involvement of the eye, usually appearing as a secondary lesion. The symptoms are usually pain, worse at night, disturbance of vision, tenderness of the eyeball, photophobia, lacrimation and a feeling of general malaise. The signs are marked pericorneal injection, constriction of the pupil and a velvety thickened appearance of the iris, sometimes with irregularities in the surface. In later cases descemetitis and posterior synechiae (between the iris and lens) may be present and there may be some exudate in the anterior chamber.

In many cases there is no apparent distinction between syphilitic iritis and that due to other causes and the etiology is learned only thru the history and laboratory tests. However, in some cases, papules appear on the iris and are pathogonomonic. Roseola is occasionally present.

The local treatment generally in use is atropine, hot bathing and a mild antiseptic wash or ointment. Pain in the early stages is relieved with acetidine, codein and Arlt's salve. Occasionally morphia is necessary. Dionin is valuable and is also of benefit in relieving pain. After the full atropine effect is gained, there is usually little or no pain.

Iritis is frequently complicated by involvement of the ciliary body, the condition being known as iridocyclitis. It is more painful and usually requires more vigorous treatment. Occasionally in treating iritis and frequently in treating iridocyclitis, it is necessary to administer foreign protein. The results are usually almost miraculous.

As mentioned above, syphilitic iritis is usually a secondary lesion but occasionally occurs in infants and children as the result of hereditary syphilis. In both types, the condition is frequently bilateral; in untreated unilateral cases, the other eye usually becomes involved a few days later.

Cumma of the iris is extremely rare but has been noted during the tertiary period, along with gummatous involvement of other tissues.

2. Choroid.

It is extremely rare for syphilis to affect the choroid only; the retina is usually involved and the condition is known as chorio-retinitis. When found it is usually appears during the secondary or tertiary stage of acquired syphilis but has been recorded in children suffering with hereditary syphilis. The symptoms, signs and treatment are more or less identical with that of chorio-retinitis and will be discussed under that head.

C. Tunica Nervosa.

1. Retina.

Simple syphilitic retinitis, like simple syphilitic choroiditis is quite rare; both coats are usually involved.

Chorio-retinitis is much more common and occurs during the secondary or tertiary stage of acquired syphilis; occasionally it is found in children with hereditary syphilis. Both eyes are usually involved. The subjective symptoms are decreased vision, particularly in dim light and night blindness. If complicated by vitreous opacities, the patient may complain of "spots" before the eyes. On examination the visual fields will be found contracted, frequently with scotomata. Ophthalmoscopic examination will reveal the typical patches of chorio-retinitis. No local treatment is indicated but in addition to the usual anti-syphilitic treatment, the patient should be given as large doses of iodides as can be tolerated.

As the result of the chorio-retinitis there is always atrophy of the choroid and retinal tissues; at times this is quite extensive.

Syphilitic endarteritis occasionally complicates chorio-retinitis. The diagnosis can be made only on ophthalmoscopic examination.

2. Optic Nerve.

Besides the partial atrophy following chorio-retinitis, syphilis is the greatest single cause of primary optic atrophy. De-Schweinitz states that optic atrophy occurs in 33 per cent of cases of tabes dorsalis alone. It also occurs in insane, insular and lateral sclerosis and has been caused by direct syphilitic inflamation of the nerve.

D. Humors.

1. Aqueous Humor

The changes in the aqueous humor incident to interstitial keratitis and iritis have already been described.

2. Vitreous Humor.

As mentioned above vitreous opacities are frequently found accompanying or following syphilitic chorio-retinitis. On ophthalmoscopic examination these opacities may be seen: they are usually very fine, appearing like a mist, but may be quite large. They may also occur as a result of trauma to the eye of a syphilitic individual. As mentioned above, iodides must be used in these cases and they are sometimes benefitted by parathyroid extract.

The vision may be affected directly. Blatt recently reported a case of spasm of accommodation of vision in a tabetic. These spasms come on two or three times daily and last two to four hours; they occur daily for a few days and then disappear. I have had a similar case in my own practice, and have found strychnine beneficial.

It is hoped this brief review will be of interest and will result in better co-operation between general practitioners and oculists.

The Importance of Being a Member of Your Medical Association

BY CLYDE MADISON SPECK, M. D.
New Albany, Miss.

In view of the fact that a few members of the Medical Association do not realize the benefits they derive from their association and still a greater number of non-members hold the same opinion but a stronger one, I wish to discuss with you the importance of the association and especially being a member of the association, the benefits derived therefrom to your self and the good that you can do your fellow man by being a member of your local association at least and if possible a member of the American Medical Association.

Your local association is a component part of your state association and your state association a part of the American Medical Association. The organization of Medical men in this manner is important in that your local association deals directly with its members and is therefore in closer contact with its members and the great problems dealing with the individual physician. But it is necessary to have a state organization and a National organization in order that the efforts of each association can be co-operated in such a manner as will be of benefit to the Medical profession as well as to the people of our nation. This system of organization is similar to our county, state and national organization of our government.

The formation of societies for the Medical man is for the purpose of co-operation and promulgation of the great principles for which our societies stand, that is, a decorum of action toward our fellow man. Toward this purpose we have medical ethics that not only take into consideration the duties of one physician to his fellow practitioner but also to the community in which he lives.

In union there is strength and without this union, co-operation and assimilation of ideas, the Medical profession would be in a chaotic state. Individual effort would not have the importance that it has today under co-operation. Ideas of the greater lights in Medicine could not be transmitted to the average practitioner. There is no better method of disseminating knowledge in general, as well as of medical character, than through our Medical organizations. Every physician should identify himself with the organized body of his profession as represented in the community in which he resides because such county societies, constituting as they do the chief elements of strength in the organization of the profession, should have the active support of their members and should be made instruments for the cultivation of fellowship, for the exchange of professional experience, for the advancement of medical knowledge, for the maintainence of ethical standards and for the promotion in general of the interests of the profession and the welfare of the public. County societies ought to place themselves in affiliation with their respective state associations and these in turn with the American Medical Association.

There is no profession for the members of which greater purity of character and a higher standard of moral excellence are required than the Medical. To attain such eminence it is the duty of every physician, and every physician owes it to his patients to attain this eminence in order to gain their respect and their confidence.

We do not have to go back into past history to see what organized Medicine has done for the public in general as well as for the Medical man; although the accomplishment of organized medicine in the past, its benefits to the people of the earth, glows with radiance and has accomplished more than any other field of endeavor. This is saying a great deal but it can be safely said without successful contradiction. Let us take what organized medicine is doing for the general public at the present time.

The American Medical Association, through its individual and co-operative efforts, has done more to eliminate the charlatan and those debased individuals who prey upon the weaknesses of the infirm and the sick than any other organization could have ever done. Just take in recent months what she has done in eliminating Dr. Brinkley with his goat gland racketeering, and the elimination of quack advertisements too numerous to mention. These acts alone would justify the existence of such an organization. I could enumerate one thing after another, over a period of years that the American Medical Association has accomplished with the co-operation of local and state organizations. It would take more time than is alloted me to catalogue these accomplishments.

If it were not for organized Medicine, Medical education would not have advanced as it has and in line with the advancement of other lines of endeavor. Organized Medicine promulgates comradeship among its members. IT endeavors to promote the science and art of Medicine. IT entertains a true respect for those seniors who by their labors have contributed to its advancement. IT teaches us our moral and professional obligations to the public. IT has created a code of ethics that is for the good of Medicine in general and the public in particular. It seems to me that the greatest thing that a Medical man can do for the benefit of the general public, as well as the Medical profession, is to join his Medical Society.

Glaucoma; Recognition and Treatment

BY D. E. STATON, M. D.

In selecting the above subject as the title of this paper I did so with the idea of bringing to your attention a disease or symptom of which far too little is known. You will note that I said disease or symptom, because as a matter of fact, we do not know positively if it be a distinct disease, or only a symptom of some obscure or hidden condition of the general system or other part of the body than the eye itself.

In the state of Mississippi alone we have between fifteen hundred and two thousand cases of blindness, or individuals so nearly blind as to have no practical use of their eyes to aid them in a visual capacity. This in spite of the fact that we have in our state no large cities, and in comparison with most other states, very few factories and industries hazardous to eye-sight. Considering that the population is small by comparsion with other states you can readily see that a blind population of around two thousand is quite a marked percentage. Of course glaucoma, or other disease, is not the cause of all these blind eyes, but it is the cause of blindness in a great number of them; far too many.

Due to the fact that the general practitioner or family physician is the first one to see them in most instances, it behooves him to be especially wary, and on the watch for those cases which have pain about the eye or in the region of the temple, and also those cases in which vision is becoming noticeably dimmer even though there is no pain, for all types of this disease do not have pain though the congestive varieties are associated with it. Elderly or middle aged persons are more prone to develop this disease than are the young, and as a consequence must be more carefully watched and this fact borne in mind. It is true that young children and young adults do have it at times for glaucoma has a predisposition to run in certain families or is inheritable. I have seen only one family where this was true, but other writers have mentioned, time after time, such families.

The general practitioner has his hands well filled, and as a rule prefers to refer these eye patients to some one who devotes his time to such, but because of the strictures involved and the importance of recognizing these conditions early in their course, it is needful for him to be familiar with the more important aspects of such cases. A great many glaucomatous eyes may be suspected if by testing the vision with the ordinary letter visual chart the vision is found to be less than 20/20. If vision is less than 20/20 further examination should be made and the cause detected. It may be glaucoma, toxic or other form of amblyopia, accomdative asthenopia, presbyopia, simple errors of refraction, or any one of a number of other conditions which may upset the normal functioning of the eye. A diagnosis, of course, could not be made on such a simple visual test alone but such a test would call attention to there being some error which needs attention. Such a test can be easily done in anyones office in a very few minutes. A vast number of these with loss in vision will be only errors of refraction, but enough will be found to have something more serious, to justify making use of every available means to come to a correct diagnosis.

We do have an occasional case of glaucoma in which vision equals 20/20 or more, but these are very infrequent and the patient himself may no know there is anything amiss until vision becomes less than 20/20, or until his lateral fields are very much constricted.

The more technical side of the examination, such as the use of ophthalmoscope, tonometer, and perimeter, is in the realm of the eye specialist and may be left to him, as their use requires perhaps more time than the average practitioner would care to devote to them.

Certain cases of glaucoma have a resemblance to cataract to the untrained eye, and on microscopic examination alone, but these should not deceive one if a careful examination is made.

As you well know, glaucoma is a disease or condition of the eye in which an increase of intraocular tension, and diminution in vision, are two of the cardinal symptoms; this being especially true in the later stages of the disease. It is a very common disease and may be associated with cataract or other eye disease, thus being overlooked because of this association.

Glaucoma is divided into two principal types of varieties—primary and secondary—, primary when it seems to be a distinct disease in itself, and secondary when accompanied by, or rather as a result, of some other disease or injury. It may be further divided into the congestive and non-congestive forms.

Glaucoma has been known since ancient times, though knowledge of it was confined to the congestive types, because of the fact that the non-congestive form cannot be positively diagnosed without the use of the ophthalmoscope, with the help of the tonometer and perimeter. The ancients thought glaucoma was connected in some way with gout and for that reason called it ophthalmia arthritica. This is now considered an erroneaous idea for it is thought today that the increase of tension is caused by blocking, or interference with the outflow of the intraocular fluid. In the primary disease we cannot always be sure of the direct cause of this blocking or outflow, whereas in the secondary glaucomas it is easier to find the source of trouble; this cause frequently being the result of an old iritis, luxated lens, or some similar disease or injury. One can readily see that an old iritis with seclusion of the pupil, might easily be responsible for a walling off of the anterior from the posterior chamber, and thus interfere with proper drainage and flow of the fluids. The inevitable results of a continuation of inflow and cessation of outflow would be the expanding of the coats of the eye ball proper, and as the lamina cribrosa is the weakest or most resilient portion, it would be first to feel this pressure. This being so, the lamina cribrosa at the optic nerve head would recede. or "give" backward, causing a cupping or pitting of the nerve head itself, because the nerve fibres also recede just as does the lamina.

In making a diagnosis this pathological cupping must be distinguished from the normal physiological depression, which is usually very easy: in glaucomatous cupping the disc edges dip downward very precipitously or abruptly, and in some cases the edges overhang as if they were undermined. This must be determined with the ophthalmoscope as the ocular fundus cannot be seen otherwise. As the retinal vessels dip downward into the glaucomatous disc they may disapper under the disc margin and their course appear interrupted. Because of the increased pressure the size of the retinal vessels are reduced, and in the advanced cases of glaucoma the optic disc is usually whiter because of a certain amount of atrophy of the nerve.

Because of the fact that we occasionally see a physiological cupping of the nerve with undermined edges, we place reliance on the tonometer and perimeter as well as on our ophthalmoscopic picture. Perhaps we take a tonometer reading and find the tension within normal limits, if so we take the reading at another time, or perhaps several times before we find the tension raised.

The perimeter, or instrument for taking the visual fields, is very important; with this instrument we determine the range of vision, or the extent of vision laterally, up and down, or in the various meridians.

In glaucoma this range of vision is reduced, and especially so on the nasal side. This visual field may be taken in colors; blue, red, green and white, but for most practical purposes the white form field is sufficient.

In non-congestive glaucoma, or glaucoma simplex, the tension increases gradually without inflammatory symptoms and the patient may have good central vision, enough to read perhaps, but with virtually all other vision destroyed. For this reason they may not be aware of the loss in sight or the amount of destruction that has been done. Again, one eye may perhaps be affected with acute glaucoma and the other eye have glaucoma simplex. Due to the fact that the acute eye is so plainly in trouble, we may overlook the other apparently good eye and thus do the patient a great wrong.

In congestive glaucoma the symptoms are much alike in the acute and the chronic forms, but are more intense in the acute, and come on much more gradually in the chronic type and are milder. Symptomatically, vision is diminished, pain is present, objects appear smoky or foggy, when looking at an artificial light it may appear to have a halo around it, dilation of the pupil is often noted, the anterior chamber is probably more shallow than normal, the cornea looks hazy, the conjunctival vessels are somewhat engorged, the tension is increased, the lids may be edematous, there is ciliary and episcleral injection, the iris appears dull or muddy in hue. Because of these symptoms glaucoma is often mistaken for iritis and for this reason atropine may be dropped in the eye, thus exciting the eye more. It may also be mistaken for acute conjunctivitis and more valuable time lost while being treated for this disease.

The symptoms of the simple glaucoma are usually progressive loss in sight, contraction of the visual field, at times slight attacks of obscuration, and perhaps some cloudiness of the cornea though this is not constant.

A great many operations and numberless medicines and other forms of treatment, have been instituted in the hope of giving more lasting relief for glaucoma, but up until the latter half of the last century no worthy mode of treatment had been worked out. About the year 1856 Mackenzie tried to relieve the tension by corneal paracentesis, but found no permanent benefit accrued from this method. Soon after this Von Graefe began the treatment or operation that we most frequently use today. He found that iridectomy came nearer being the ideal treatment than anything previously tried, and up to the present time we still use some form of iridectomy as the operation of choice. Other operations have been tried and are still being tried but we have added very little or nothing, to iridectomy as standard treatment. However, in my experience sclerectomy, as exemplified by Elliott's trephine method, has proved to be best, if tension in the eye is not too high. This operation is in reality combined sclerectomy and iridectomy, and is done with the idea of leaving a permanent scar or cycatrix through which the fluid filters or escapes, and in this manner keeps the tension at or near normal. Other operations tried are legion, and can be made familiar by study of any text book on eye surgery.

Of other methods of treatment there remains medical treatment in its various applications; constitutional, instillations in the conjunctival sac, injections beneath the conjunctiva, and message to the eye bulb. All sources of focal infection, such as diseased tonsils, carious teeth, paranasal sinuses, intestinal tract toxemias, gall bladder disease, etc., should be cleared up. Proper rest, necessary diet, avoidance of overwork and nerve strain, all these must be looked after. As for eye instillations (miotics) these may be employed with advantage in certain cases, if the patient can be seen regularly and the visual field taken when necessary, as well as close observance of the tension. This applies more specificially to the chronic congestive and the non-congestive types. Massage of the eye ball through the closed lids may be of service in selected cases, though in my experience it has not been of much benefit, as my patients have done as well without massage as did those to whom it was applied. The medicines used to keep down abnormal tension of the eye ball are few, the ones most generally used being eserine and pilocarpine, though within recent years a new preparation known as glaukosan has been introduced. Eserine and pilocarpine are pupillary constrictors and by this constriction of the iris tend to reduce intraocular tension. As for glaukosan, I saw this medicine used in six cases a few years ago, or soon after it was introduced, and no advantage over eserine or pilocarpine was noted in these few cases, though these are perhaps too small a number to judge definitely of its merits.

In the painful varieties of glaucoma, symptomatic treatment such as hot, moist compresses, dionine, morphine, etc., in addition to eserine or pilocarpine, may be used until operation can be done, but the sooner operation is done just that much nearer are we to conserving normal vision.

Summary:

1. Importance of locating the cause of all headaches.
2. Importance of locating the cause of loss in vision.
3. The danger of mistaking acute glaucoma for other eye diseases.
4. Use of the ophthalmoscope, tonometer and perimeter as an aid to diagnosis.
5. Methods of treatment; operative, medical constitutional, etc.
6. Operative treatment the method of choice.

DISCUSSION OF DR. STATON'S PAPER, "GLAUCOMA"

Dr. Hamrick: I am sure we have all enjoyed this excellent paper read by Dr. Staton. There is little to add, but a few things we might stress. The hereditary factor is important. Glaucoma is more common in females than in males, and more common in far-sighted people than in near-sighted. Acute glaucoma is so dramatic, the pain is so excruciating, that diagnosis may be immediate, but in secondary glaucoma, accomodation begins to fail and there is gradual diminution of vision. There might be some changes in the lens to lead to a diagnosis of cataract, but very often an arterial pulsation in the disc may be detected as an unerring symptom; the retina arteries are small and the veins large.

Dr. Staton: I failed to mention one thing that we frequently see, and that is that we are apt to have quite a dilatation of the pupils. In acute glaucoma, the symptoms and pain may come and go, but an examination of the eye shows that it is not normal. I want to thank Dr. Hamrick for his discussion.

Book Reviews

"Psychology and Psychiatry in Pediatrics" is another of the series of reports published by the Century Company, New York, of the White House Conference called by the President last year. This is a book which presents a new field which until recently the general practitioner seldom considered within his territory. But the discussions clearly indicate that a physician cannot adequately administer physical care for the child without recognizing a close relation to the emotional and intellectual development from which arises or to which allied the difficulty presented. A direct challenge is flung the practitioner who knows his patient from infancy to adolescence and who is in a better position to deal with the problems involving the personality of the child than the specialist, because of the opportunity he has of co-operating with the parents. A definite field designated for the expert, but the doctor is urged to avail himself of special knowledge sufficient to correlate his medicine with psychology. Price: $1.50.

"Body Mechanics", a third of the publications which have come to us from the White House Conference is a thorough and comprehensive treatment of the work that is being done by various agencies to promote good posture and body mechanics as a very important part of health. Analysis and special attention are given the development of the skeleton, the muscular and the visceral systems from infancy to adult life. Emphasis is placed upon the need of an informed lay to encourage the use of proper clothing, exercise, respiration, posture in its various phases as they are directly related to the health and normal development, physically and mentally, of the child. Extensive extracts are reproduced from the discussions of eminent authorities on the subject at the Conference. Published by The Century Co., Price: $1.50.

"The Matas Birthday Volume"—A collection of Surgical Essays written in honor of Rudolph Matas, New Orleans, with Portrait. New York, Paul B. Hoeber, Inc. October, 1931. 396 pages, 102 illustrations, 5 in color. Price: $10.00.

The Matas Birthday Volume, prepared under the auspices of a group of his friends and former pupils in honor of his seventieth birthday, is a surgical classic of the highest order, and a well fitting tribute to one who is such a towering figure in the world of medicine.

The first chapter is devoted to the "Appreciation of Professor Matas", which contains quotations and reminiscences of Dr. Matas, portraying his magnetic personality, his ability as a literator and humanitarian, and his mastery of surgery.

Several contributions are on vascular lesions, a subject in which Dr. Matas is very interested, and to which he has contributed much. Dr. Mont Reid's and Dr. Hubert Royster's are especially appropriate, because they refer to the principles taught and emphasized by Dr. Matas on the treatment of aneurysms. Dr. R. Leriche, of Strasbourg, writes on arterectomy for localized arterial obliterations; Dr. R. Alessandri, of Rome, furnishes an interesting paper on sympathectomy for Raynaud's disease and thromboangitic gangerine; Dr. J. C. Bloodgood, Baltimore, writes an excellent paper reminiscent of Halsted's surgical triumphs at Johns Hopkins 36 years ago. This contribution is very appropriate, because of the great admiration which Dr. Matas and Dr. Halsted had for each other.

Drs. F. J. Hoffman, S. J. Horsley, and J. B. Deaver, respectively, present papers on cancer. That of Hoffman's concerns itself with cancer in the North American negro, a subject which has interested Professor Matas very much. The study shows that there is an increasing mortality rate among the negro race, which approaches that of the white race, and that the mortality rate of cancer of the genital organs is much higher in negro women than in white women. Horsley's paper on cancer of the stomach covers the subject thoroughly. He emphasizes the importance of partial gastrectomy in early gastric cancer, and shows that, when done, the percentage cured are comparable to those after the radical operation for cancer of the breast. Deaver's presentation on cancer of the breast, gives his end results obtained in 221 cases.

Contributions concerning surgery of the in-

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testinal tract are given by Dr. J. M. T. Finney, Senior and Junior, Dr. Robert C. Coffey, and Dr. E. Ribas y Ribas, of Barcelona, respectively.

Dr. George W. Crile furnishes an interesting paper on anesthesia. He discusses the various anesthetics which have been used in recent years and stresses the important role Professor Matas played especially in the development of spinal, local and induction analgesias.

Dr. Paul Moure, Paris, in an article, gives the technic of total rhinoplasty, his favorite technic being the total removal from the forehead of a flap of skin and the reconstruction of the nose.

Dr. Joaquin Trias-Pujol, Barcelona, discusses the biliary fistulas that remain as the result of the opening and marsupialization of hydatid cysts; Dr. William J. Mayo, emphasizes the important role of the special senses in the development of science; Dr. D. P. D. Wilkie, Edinburgh, very forcibly and clearly gives the indications and technic for splenectomy.

There are two interesting papers concerning thoracic surgery, by Dr. Howard Lilienthal, and Dr. Evarts Graham. Lilienthal discusses the operative treatment of pulmonary tuberculosis, and stresses the importance of individualizing the therapy to the individual patient. Graham discusses the associated reaction in the bronchial mucosa with infections of the upper respiratory tract.

Of the total 21 contributions, all are of surgeons of international reputation. The printing and general set-up of the volume leaves nothing to be desired and on the whole it forms a very worthy appreciation of the conspicuous services of the distinguished surgeon. Anyone who would like to possess an excellent specimen of literature and professional craftmanship would do well to secure a copy, the edition being limited to 1,000 copies.

W. M. ADAMS, M. D.

News from the Ole Miss Medics

At the recent meeting in Chicago, the Council on Medical Education and Hospitals of the American Medical Association decided that definite action in regard to the University of Mississippi Medical School should not be taken until the next meeting of the Council which will be in New Orleans in May. The reason for postponement of action by the Council is to give the new Board of Trustees of the University and Colleges of Mississippi, which has just been appointed by Governor Mike Sennett Conner, the opportunity of taking the necessary steps which will lead to the restoration of the Medical School to full standing in the Assiciation.

Just as the heroic efforts of Dr. P. L. Mull and Dr. J. C. Culley, the former Dean of the School and the latter President of the State Medical Association, and the appeals made by these two men to the authorities of the American Medical Association prevented the Ole Miss School

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from being dropped completely from membership as a result of the 1930 political shake-ups, so it is thought that the work of these men was the chief reason of the Council for granting additional time for the fulfillment of requirements which must be met in toto if the School is to gain full reinstatement.

Upon his return from the Chicago meeting, Dean Mull declared that the future of the University Medical School depends solely upon those in authority in the State of Mississippi, and expressed absolute confidence in Gov. Conner and the new Board of Trustees, and that they would do everything humanly possible to save the Medical School.

It is hoped that the members of the medical profession of the state as well as the many people familiar with the work and record of the school will use their influence to make it possible for the requirements of the Association to be fulfilled. It would indeed be a calamity to deprive the Medical School—the only school which has been able to keep its "A" rating (even though that rating be probationary) during the worst of adverse conditions under which the University of Mississippi has been laboring—of the right to enjoy the excellent opportunities which are to be effected by the new higher educational system in Mississippi. It is believed that the physicians of the state and those in authority will make it possible for the necessary steps to be taken by the time of the next meeting of the council.

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The members of the student body of the University of Mississippi Medical School and the faculty of the school had the pleasure of attending the Mid-South Post-Graduate Assembly on Wednesday, Feb. 10th. Dean Mull declared a holiday so that the students might take advantage of the opportunity to enjoy the program of that day. It goes without saying that the day proved to be a great success from the standpoint of the "embryo medicos".

Dr. P. L. Mull and Dr. J. C. Culley have been attached traveling companions since the acceptance of the Deanship of the University of Mississippi School of Medicine by the former and the election of the latter to the Presidency of the Mississippi State Medical Association.

These two men have visited every medical society in the state with the possible exception of one during the past twelve months, and have brought the physicians and surgeons of the Magnolia State into close contact with the work of the Medical School and the State Medical Association. Consequently, the students of the Ole Miss Medical School are informed as to those subjects which are foremost in Medicine in Mississippi today, and the State Association is more highly organized and more efficiently functioning than ever before.

Dean Mull and Doctor Culley attended the meeting of the South Mississippi Medical Society that was held in Laurel on March 10th. On the following Tuesday, March 15th, they were present at the meeting of the Northeast Mississippi Thirteen County Medical Society in Booneville. Three members of the first year class of the Medical School had the pleasure of attending the meeting in Booneville, and returned to tell their comrades of the excellent program that they heard.

Dr. Culley and Dr. P. W. Rowland, professor of Materia Medica and Pharmacology, were accompanied by members of the second year class to the meeting of the Northeast Mississippi Seven County Medical Society in New Albany on March 16th.

The mileage covered in the various trips by Doctors Mull and Culley is well over five thousand.

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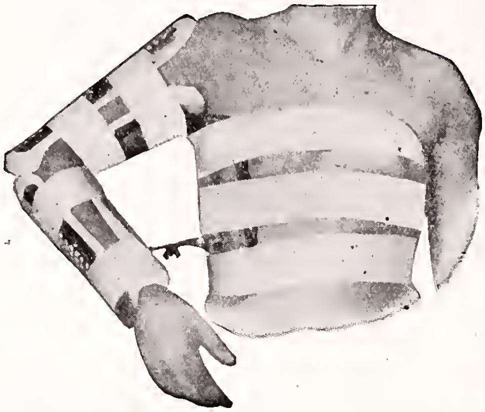

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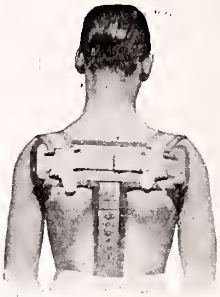

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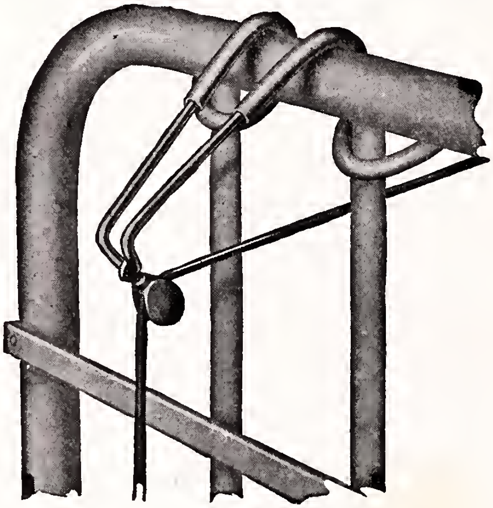

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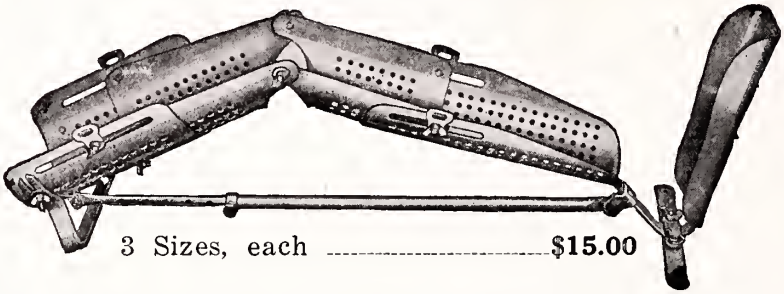

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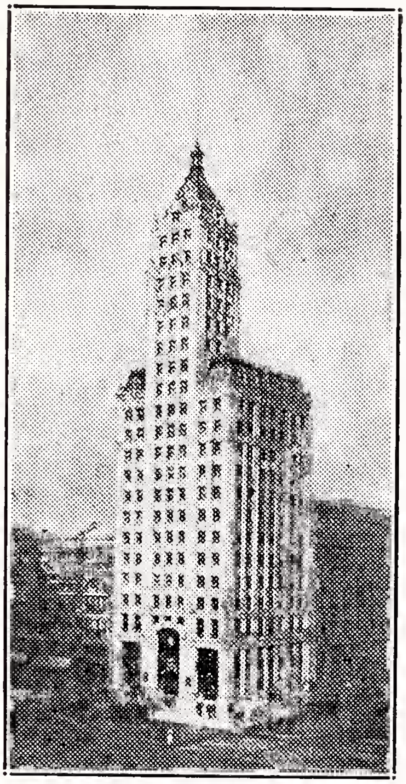

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And yet whose work is never done?
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"Who's roused up in the dead of night
By some one in a dreadful fright
Who's sure she's going to die tonight?
The Doctor.

"Who when the days are shocking hot
Can seek no cool sequestered spot
Because he must be on the trot?
The Doctor.

"Who when the mercury is low,
Long weary miles must often go,
Through cutting winds and blinding snow?
The Doctor.

"Who has to hear the countless ills
And deal out multitudes of pills
To those who never pay their bills?
The Doctor.

"Who must not show that it's a bore
To hear each family history o'er
Five generations back and more?
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"Who should be placed among the saints
Whom history with us acquaints
For patient listening to complaints?
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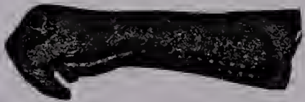

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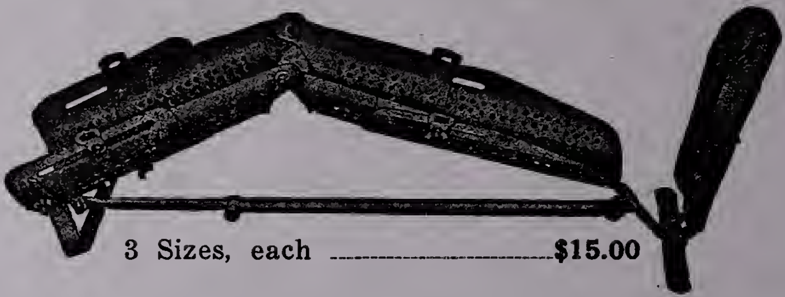

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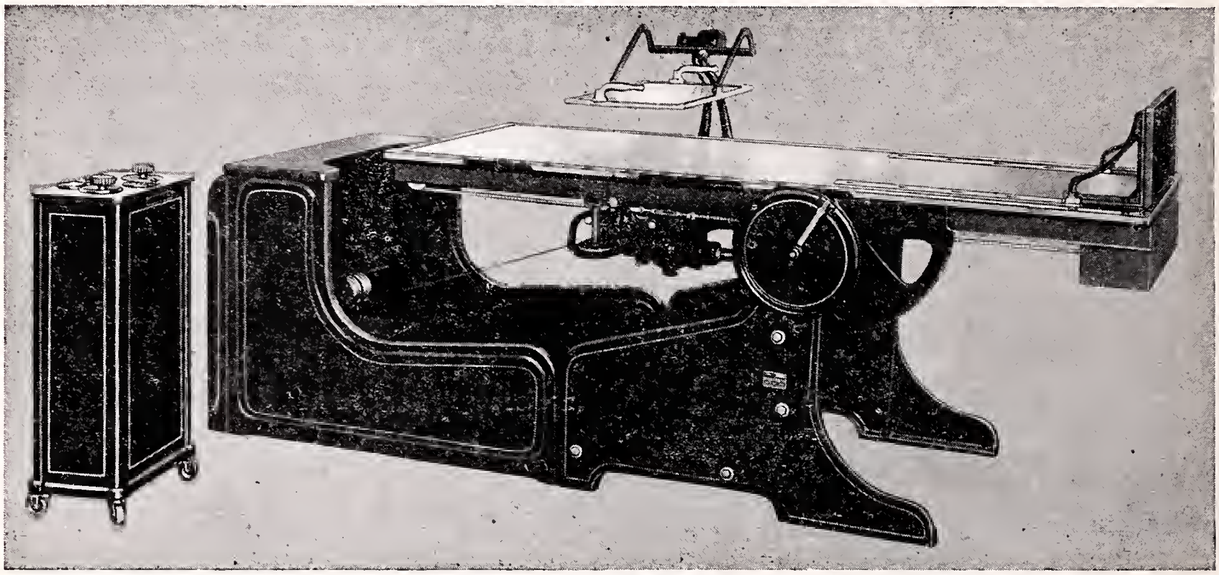

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Our two year medical department has been threatened by a legislative committee. We want to admonish them to go slow and to be more careful in their statements. We trust that they will read Dr. Culley's address in full and get the facts more clearly before them. We can not afford to give up this school. It has rendered too much service. It has much more to do. Our man power is our greatest wealth. Its education and the conservation of its health is our most important duty. We need to give our own young men a medical education and we need to have their services. Many young men a medical education and we need to have their services. Many young men who have the medical soul throbbing within their bosom can go to Ole Miss for two years who are unable to go out of the state for the four years. It is not too expensive Mr. Legislative Committee. Don't say this again. It is an investment that you can not afford to not make. When you get in debt you must invest and make profit to enable you to get out. It is true that Mississippi is now convalescing from Typhoid financially speaking, but if you buy an educational suit to fit at this time, if the state lives, and live she will, then in a few months or years at most, you will have to discard a good suit and buy another one. You will have a waste. We can not give up our medical school. We can not, we must not, we will not. Let every member of the profession come to its aid at this time.

The British Medical Journal, London, contains the announcement that at a meeting of the Council of the Royal College of Surgeons of England, Lord Moynihan, President, in the chair, The Right Hon. Lord Dawson of Penn, P.C., G.C., V.O., K.C.B., K. C. M. G., Physician to His Majesty the King, and President of the Royal College of Physicians of London, and Sir Henry Wellcome, LL.D., F.S.A., founder of The Wellcome Research Institution, were elected Honorary Fellows of the Royal College of Surgeons.

The Royal College of Surgeons of England is one of the most exclusive scientific bodies in England, and the bestowal of this honor on Sir Henry Wellcome is very exceptional in that aside from members of the Royal Family, Sir Henry is the second person not holding a medical degree upon whom this rare distinction has been conferred, the first and only other recipient being the famous Field Marshall, Lord Roberts of Kandahar.

Sir Henry Wellcome is of American birth and is well known for his world-wide scientific work and extensive pioneer researches in connection with tropical diseases, including the founding of The Wellcome Tropical Research Laboratories at Khartoum on the Upper Nile Regions of the Sudan, Africa. He is also a Director of the Gorgas Memorial Institute, Washington, D. C., with its Tropical Research Laboratories at Panama.

Our state meeting was moved up to April to get out of the way of the A. M. A. It was held in Jackson, our state capital, at the new Robert E. Lee Hotel, which hotel did itself proud in entertainment. Dr. J. C. Culley was president. His address was on medical education. It was able and instructive. He made a strong plea for the medical department at Ole Miss. Dr. W. S. Leathers, former dean of Medicine at Ole Miss and Secretary of the Board of Health of Mississippi, and now Dean of the Medical Department of Vanderbilt University was the orator of the occasion. He spoke on the relation of public health and general practice and the future outlook of both. It was a masterful oration. Every physician in the state, in fact every citizen should have heard both addresses. They should yet be published in every paper in the state. Mississippi can ill afford to lose the medical department at Ole Miss. It is reaching many worthy young men who are permeated by the medical spirit and who could not go out of the state for the full four year course. It is not costing the state so much as some legislative committees would have us believe. Our two year course stands at the top of the list for the ten two year schools in the U. S. A. Legitimate public health is our great barrier to state medicine. Dr. Leathers paid high tribute to our public health department. We still claim Dr. Leathers. We are just lending him to Vanderbilt.

The different sections presented fine programs. Dr. Edley Jones was alive on the job for the eye, ear, nose and throat department, Dr. Smith of Vicksburg, one of the outstanding public health officers of Mississippi and the South did himself honor for his department; Dr. Rembert put up a strong bunch of essayists, the surgical section came up strong, and Dr. Adkins deserves plenty of honor for his program on the radiological section. Dr. W. W. Robinson's discourse on chronic appendicitis with his slides was in keeping with the masterful student he is. Dr. Martin of Dallas on the Cancer Problem was worth crossing the continent to hear. Dr. Rembert's program was strong throughout. Dr. Brown of Little Rock suggested a most valuable line of thought peculiar to practice at this time along the suicidal tendencies of the times. We did not hear many of the papers of the eye, ear, nose and throat section and public health, but we heard enough to make us know that they were up to a high standard. The local men in all departments had fine papers as well as the out-of-state essayists. On the surgical section Drs. Sanders, Dabney and Haggard brought forth much favorable comment. Dr. Sanders is one of the thorough students of the South, Dr. Dabney is a native of Mississippi, one to whom we love to do honor and in whom we feel a pride, an able gynecologist and editor of the Southern Medical Journal, while Dr. Haggard is a former president of the A. M. A., a surgeon of national reputation, and a ranking orator of the "world."

Six hundred and sixty-six registered at the state meeting. Taking into consideration the "times" this was a wonderful showing. It is evidence of the fine work President Culley did as president. Nothing counts like the spoken word impressively said. Dr. Culley traveled the state, carried his ideas and conveyed those of one section to another. His work as president was monumental.

Dr. Lowrey Rush of Meridian is a new member of the Council. He is a thorough student, full of medical optimism, and he possesses a personality charged with inate culture and refinement. He will do honor to the honor conferred upon him.

Dr. Dicks of Natchez is the president elect of the State Medical Association. He has served as secretary of the council for a number of years. For many years he has rendered valuable service to organized medicine in Mississippi. He is one of the most systematic thinkers and workers in the medical profession of Mississippi. In physique he is perhaps our most distinguished in appearance. He has plenty of personality. He practices medicine with ease because of the love he has for it. We predict for him an able administration.

Dr. Joe Green is another new member of the council. Dr. Joe has the mother wit. He is an outstanding medical philosopher. He will make a fine member of the council.

The Mississippi State Hospital Association had a most successful meeting at the Edwards Hotel on Monday April 11th. Dr. Leon S. Pippincott did honor to the association as its president. He is a systematic worker and does not let up until victory is accomplished. Will Ross of Milwaukee was the special speaker of the evening. Gov. Conner was unable to attend. Dr. J. Gould Gardiner of Columbia was elected president of the association. This honor was well and worthily bestowed. Dr. Gardiner is one of the sane, sensible and sound surgeons of the state. He can be depended upon for safe leadership. Much good will result from these hospital meetings. We must put more business into hospital management. We must learn what constitutes the essentials and must leave off a lot of the expensive show. With all due respect to everybody, we have not had very much real sensible business applied in our hospitals, generally speaking. Hospitals can yet be operated for less money and still furnish more efficiency and can make some profit on the investment. The hospital organization of our state has before it a great outlook for service.

The next meeting of our society will be held in Amory. It will be good to be there.

The American Medical Association will hold its annual session in New Orleans, May 9th to 13th. Mississippi should be well represented. The A. M. A. is a great organization. New Orleans is a wonderful city in which to visit. It is the oldest and the newest, the most beautiful and the ugliest, the most cosmopolitan and the most provincial, the most learned and the most ignorant, the most progressive and the most backward of any you will visit. But it is a friendly city. It is a city you will love. It grows on you. It is the home of Tulane, the greatest all-round under-graduate medical school in America. Tulane is making rapid strides under Dean Bass, a native Mississippian, who makes our hearts swell with pride. It is the home of Dr. Rudolph Matas, our most versatile professional mind, the man with a medical soul and a missionary heart. New Orleans is the home of one of the book stores of Dr. J. A. Majors, a native son of Booneville, who is always bubbling over with optimism and good cheer, one of the cleverest of the clever. Go to the A. M. A. if at all possible.

Dr. James A. Acker Jr., of Aberdeen, our efficient secretary, is now president of the Mississippi State Medical Association. He will do honor to himself, to our society and to the state association. He is a systematic worker. He will be actively on the job. We are proud to have Dr. Jim president of the state association.

You will read with interest and profit the paper of Dr. Norwood. In some quarters too much importance may have been attached to laboratory tests, but as a rule we do not have enough of it by a lot. This is an age that is calling for efficient application of the already known and tried medical truths. It is not so much that the doctor does not know that he lets important things slip by him on diagnosis, but it because he does not do, does not make the careful and systematic examination on every patient that he should. A blood smear, urine analysis, Wassermann test, and feces examination should be included in the routine in the first examination. It is true that we need to renew our interest in clinical symptoms, they are the sheet anchors, but the laboratory tests come hard by their side. Get the laboratory habit. Do or have it done. Heed the admonition of Dr. Norword.

Diagnosis and Treatment of Perforated Gastric and Duodenal Ulcer by Dr. R. D. Kirk with the discussions will give you the latest and the best on the subject. Dr. Kirk has had an unusually large number of these cases. Personally we are strong for the "Cold Patch" plan having had four cases, two gastric and two duodenal without the loss of one. We also believe in drainage in the average case.

Dr. Philpot, Secretary of the Hospital Committee, made a report to the association at its recent meeting. The report was accepted and the committee was continued. The bill being sponsored by the committee is to proportion the funds over the state on a per capita basis. This is fair and just. It will mean much to the development of more efficient medicine in the small town. Modern medicine is even now on its march to the country and small town. The town of two to twenty thousand population will be the meeting place of the profession and the rank and file of our population. The development of medical centers in the small town is the answer to the high cost of medical care. The equal distribution of funds by the state for the actual charity will aid this move very greatly. You should stay behind the hospital committee until this job is finished. See or write your representative.

You will notice an announcement of the meeting of the Proctological Society which is to convene in Memphis. Many general practitioners would do well to attend this society. A rectal examination needs to be made a hundred times more often than it is. The general practitioner needs to have a general knowledge of rectal diseases and he needs to know when they should be referred to the specialist.

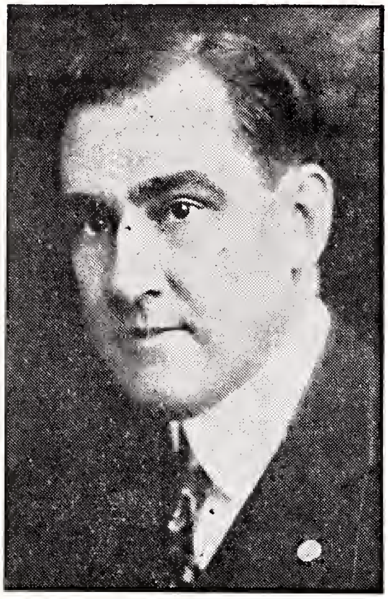
For the next thirty days we are offering The Mississippi Doctor for one year for one dollar. The Mississippi Doctor has a mission. It has been the champion of the small hospital. It is the leader of modern medicine to the country. It is trying to raise the efficiency of the general practitioner of medicine and surgery. It is the journal of the rank and file of the profession. It stands for every good cause in which the entire profession is interested. We believe you will be pleased with the journal. Some of you have had it without cost. You can be a help to the journal. The journal will help you. Will you not help us to double the subscription list. Send us your one dollar for your subscription. Ask your friends to subscribe. Help your self to solve your medical problems through a Mississippi Journal.

People continue to get sick and die of common every day diseases. The average practitioner should be able to do as much for eighty five per cent of those as the specialist.

We have plenty of physicians in practice to take care of the people of the United States. What we need is to sell them to the small town and rural community and de-centralize the profession.

The physician that is always ascribing ulterior motives of "politics" to his fellow practitioner will usually bear close watching.

A. F. Cooper, M.D.



The above is a good likeness of Dr. Arthur F. Cooper, Secretary of the Mid-South Post Graduate Medical Assembly, formerly the Tri-States. This association meets at the same place each year, the Peabody Hotel, all the lectures are in one assembly room. The program tries to cover major subjects in medicine and surgery. The essayists are the best that can be found in the United States. Their symposiums are the last word on the subject. It is doubtful if you can find another medical assembly that offers so much in such a short time. It epitomizes the latest and the best in profession in a four day course. It gives the essentials to the specialist and at the same time enlightens the general practitioner and teaches him to know when he should refer his patient. It has a broadening effect both on the specialist and the practitioner, helps them to corrolate their work.

Cordiality and good fellowship reigns supreme at this assembly. Southern culture and hospitality still holds strong in Memphis, Tennessee, on the banks of the Father of Waters. It is a city of satisfied inhabitants, and a city that you like to visit again and again.

The Peabody Hotel, the home of the Mid-South Assembly is not to be surpassed in America when it comes to accomodations that please the guests. It is especially suited to the conveniences of conventions.

It does seem that people are born to a purpose, that they are predestined and foreordained to a special work. At any rate you could not make out your order and get a secretary that is so suited in every detail of manner and efficiency as is Dr. Cooper. "The work we love to do physics pain." He is the embodiment of ease, pleasure and efficiency as secretary of the Mid-South Post-Graduate Medical Assembly. He knows how to select the best men in the field of medicine, he inspires them to their best efforts and he does not over look one little thing that adds to the profit and the pleasure of the attendant of this association. When the unseen hand was assorting the human parts for medical secretaries the choice pieces were laid aside for Dr. A. F. Cooper and the Mid-South Association. He is rendering a fine service to the profession of this territory along with the splendid program committee. The profession appreciates his services and those of the committee. The Mid-South Post Graduate Medical Assembly has yet a still bigger field of service. We congratulate Dr. Cooper for his part in this public service and we sincerely appreciate his efforts and accomplishments.

Book Review

"Modern General Anesthesia", by Dr. James G. Poe, and published by the F. A. Davis Co., Philadelphia, Pa., is the most replete and comprehensive book on anesthesias that has fallen into our hands of late. This is essentially a text-book so clearly and thoroughly defining the signs and conditions of each stage of operative and toxic degrees of ether anesthesia, nitrous oxide, ethylene and chloroform, that a beginner might distinguish them. The task of the anesthetist magnified by a detailed discussion, step by step, of the administration of these anesthesias, with major attention being given respiration and the problems incidental to it in the anesthetic state. A further chapter is given to the choice of the anesthetic for patients of given diseases and where special physiological and pathological conditions exist, with methods for administration, and the pre- and postanesthetic care. Non-volatile and local anesthesias likewise receive illuminative but brief attention.

Every practicing physician needs one of these books for a source of accurate reference for himself and his assistants. Price: $2.50.

Program

AMERICAN PROCTOLOGIC SOCIETY

Memphis

Friday and Saturday, May 6 and 7, 1932

Headquarters: The Hotel Peabody.

Arrangements: Dr. John L. Jelks, Memphis. Dr. Victor K. Allen, Tulsa.

TENTATIVE SUMMARY OF EVENTS

Friday, May 6th—

8:00 A.M.—Registration—Hotel Peabody.
9:00 A.M.—First Session—Hotel Peabody.
1:30 P.M.—Second Session—Hotel Peabody.
7:30 P.M.—Third Session—Hotel Peabody.
9:30 P.M.—Annual Executive Meeting (for Fellows only)—Hotel Peabody.

Saturday, May 7th—

8:00 A.M.—Operative Clinics—Memphis General Hospital—Dr. John L. Jelks, M.D., F.A.C.S., and Associates.

10:00 A.M.—Pathological Demonstrations—Pathological Institute, University of Tennessee, Dr. H. C. Scheisser, Director.

Proctozoology—Dr. John A. McIntosh, Pathological Lab., St. Josephs Hospital. Miss Helen Peck Bacteriologist, Baptist Hospital.

2:00 P.M.—Fourth session—Library, University of Tennessee.

7:00 P.M.—Annual Society Dinner—Hotel Peabody. (Registered Guests Invited.)

Sunday, May 8th—

Tour of Memphis and surroundings. Automobiles at Second St. entrance, Hotel Peabody.

THE SCIENTIFIC PROGRAM

will include the following presentations:

"Prophecy and Fulfillment"—Presidential Address Dr. W. O. Hermance, Philadelphia.

Addresses of Welcome—Dr. P. W. Toombs, President of Memphis and Shelby Co. Medical Society, Memphis. Dr. O. M. Hyman, Administrative Officer, University of Tennessee, Memphis.

"The Literature of 1931"—Cecil D. Gaston, M.D., F.A.C.S., Birmingham.

"Sarcoma and Melanoma of the Rectum"—Herbert I. Kallet, M.D., F.A.C.S., Detroit.

"Detached Tunnel Skin Grafts Into Stricture of the Rectum"—Raymond L. Murdoch, M.D., Oklahoma City.

"Colonic Mucorrhea"—Curtis C. Mechling, M.D., F.A.C.S., Pittsburg.

"The Mucin Treatment of Colitis"—Clement J. DeBere, M.D., F.A.C.S., Chicago.

"Malformations of the Anus"—Victor K. Allen, M.D., Tulsa.

"Histology and Embryology of the Ano-Rectal Line"—Hary E. Bacon, M.D., Philadelphia.

"Anal Anatomy and Anal Terminology"—James K. Anderson, M.D., Minneapolis.

"Recto-Urethral Fistula"—Charles E. Howard, M. D., F.A.C.S., Cincinnati.

THE SYMPOSIUM ON RECTAL CANCER

The program committee offers as the special feature of the Scientific Program for the 1932 meeting a comprehensive consideration of every phase of ectal malignancy; the symposium will be given on Friday afternoon.

The subject will be divided as follows:

"Anatomy and Etiology"—Charles E. Pope, M.D., Chicago.

"Diagnosis"—Louis A. Buie, M.D., F.A.C.S., Rochester, Minn.

"Preoperative Treatment and Palliative Colostomy"—Descum C. McKenney, M.D., F.A.C.S., Buffalo.

"One and Two Stage Perineal Procedures"—Walter A. Fansler, M.D., F.A.C.S., Minneapolis.

"One Stage Abdomnoperineal Procedure"—T. E. Jones, M.D., F.A.C.S., Cleveland.

"Two Stage Abdomnoperineal Procedures"—Dudley Smith, M.D., F.A.C.S., San Francisco.

"Operative Complications and After Care"—Louis J. Hirschman, M.D., F.A.C.S., Detroit.

Discussion of the Cancer Symposium will be led by:

John L. Jelks, M.D., F.A.C.S., Memphis.
Jay L. Clemons, M.D., Los Angeles.
Curtice Rosser, M.D., F.A.C.S., Dallas.
Jerome M. Lynch, M.D., F.A.C.S., New York City.

A Plea for More General Use of Laboratory Methods as an Aid in Diagnosis

BY DR. CARL W. NORWOOD
Corinth, Miss.

It is presumptous on my part to attempt to relate to you that the laboratory is essential to all engaged in the art of healing. That is not my purpose in coming before you on this subject; but the fact remains that most of us, who have not grown up with the use of the laboratory since our beginning the practice of medicine, do not depend upon it as we might.

There are so many instances where, if we were to apply the aid of the laboratory, it would save many patients who drift away to some cult or to someone else. There are cases which we visit for the first time, for example, the patient who has a chill with perhaps some other vague symptoms; the fact is ,we do not know what the diagnosis really is. As a result, we give the patient symptomatic treatment and along with it the grayhairs in our head multiply from day to day as we wonder if the patient will improve, knowing not from day to day what to expect. I suggest to you tnat the laboratory will save you much worry and not only save you these gray hairs and wrinkles, but you will really do justice by the patient and yourself in some case every day if you will carry a few slides in your case and when you visit a case where you have uncertainties, get a smear of a drop of blood on a slide and perhaps a specimen of urine from this patient.

And in case you are not equipped to make these examinations, send one of the family with these specimens to your nearest laboratory. Perhaps tell him that there will possibly be some charge for this but that it is necessary in the patient's behalf in the procedure of further treatment.

If you are not satisfied with some reports as to their significance in various findings it is easy to find out the significance of them in a relatively easy manner, for the laboratory will be able to give you their significance in must instances.

We have also that large percent of cases of so-called KIDNEY TROUBLE, "yes, awful kidney disease for so many years." "I have been given up", the patient will brag, naming a number who have treated him. "I have the incurable kind," they often say.

It is a bit enlightening to examine this patient's urine chemically and miscropically and be able to tell him all findings are normal. I mention this because we do find many of such cases.

And by elimination in adequate laboratory tests mentioned, we may then locate the true condition by further examination as being some local trouble. But it is the greatest leap in the dark that I can imagine for anyone to attempt to treat any kidney disease, let it be present or imaginary, without the aid of laboratory findings.

Another case of chills comes in. And we say, "Oh yes, malaria," and fill in with quinine. The patient grows no better, day after day, but grows worse. We wish for light, darkness is in our pathway, and we toss on the pillow. In the first place, what should have we done? We should have got that patient's urine and a drop of blood on a slide and sent it to a good laboratory. It would have returned with a report. No malaria, high leucocyte, urine shows 2 to 4 plus, plus. Had we known this in the beginning we should have had our bearings and done justice by the patient.

Then we have cases of anemias. I mean those that are diagnosed from their appearance. We tonic, we tonic, we tonic. Let me say that there never was an anemia without a cause, and it is neither justice to ourselves nor to the patient if we have not got the laboratory reports, at least of the blood and urine, whereby, we find the cause and remove it, so that nature may then take hold and the patient's blood restore itself.

I realize that about as worthless a thing we can have is an undependable technician in laboratory. On the other hand, I cannot put too much stress on their importance to you, who have not availed yourself the aid of the laboratory daily. I believe if every practitioner would carry microscopic slides in his case in the place of purgative pills we would be able to save a much larger percent of the appendix cases at operation. Why we will continue to give dynamite doses of calomel, C. C. Pills, Castor Oil, and other such purgatives, in the face of all that has been said, is a mystery. When we visit a patient with a pain in the belly, let me suggest that we empty this patient's stomach in a simply way. Get him to vomit. I know of no better way than to give him several glasses of soda water then get him to stick his finger back of his tongue until he vomits, repeating this until it is free of food. Give this patient enema, heat his belly and, if necessary, an opiate to ease. Then get a drop of blood on that slide, and send a runner to a laboratory. If you have infection in the abdomen your test will indicate it. If not, your patient will possibly be well in a few days, then you can give him the purgative to hold your reputation and not for the good it will do.

We are realizing the increasing number of amoeba cases in this climate. We do not know if they are increasing or if more of us are using our laboratory facilities and are finding them more. A large percent of these, you know, give no symptoms directly, while others may be in a debilitated state from it.

I dare say there are half of the people who think we get malaria from the air, the water we drink, or from getting their feet damp, or from a poor watermelon. We can correct this by making a blood test and stating to them the facts as to how it is spread and cured. "Oh", they say, "I had to take purgative to free myself of malaria, and still the chills come on every other day." When we find Mr. Malaria plasmodium, we know that patient needs quinine for at least six weeks, then after that perhaps, until his blood shows that he is well.

The death rate in child birth is one of the few conditions which has not decreased. We know positively this could be cut down to an unknown quantity if we would get the urine of these patients at two-week intervals and apply appropriate treatment, as well as the routine blood-snear about twice during gestation. I do not mean this would take care of the need or necessity of these patients being cared for at hospitals, which is another important step necessary to save the life of many mothers, who are being daily lost, but I mean it is imperative to have this laboratory work done and the necessary treatment afforded to get this mother to time of delivery, so that she will have an equal chance of going through the delivery with a chance that is justly hers and to the child.

I am sure that both chemical and microscopic tests are necessary and indespensable if we are to do the job right. The reasons for this are too volumnious for me to go into at this time. But a large number feel as I do, personally, that laboratory work, to do it myself, is the brunt end of medicine, and to the average busy doctor, when he depends upon himself to do it, does that only which he has to. I do not believe any doctor will give it the time and detail that it deserves in his work, if he depends solely upon himself to do it, for no one minute of his existence is his. By the time he begins a test Johnnie comes running in with his toe mashed, or similar things. The doctor as a result says, "Oh, well, we will treat him for malaria, and let it go at that." That to my mind, is the reason for the prevalent neglect of this work. The majority of us are trained in laboratory work, but at this time we are grossly neglecting the essentials and hitting only the high points. I will relate two cases which have impressed me very much in recent months. One was a man who had been diagnosed for twelve years by his family physician for pulmonary tuberculosis. After blood tests, sputum and X-ray, it proved to be syphilitic lungs. A condition, of course, or a disease, which responds readily to appropriate treatment. During this time the wife of this patient had given birth to three still-born children. This mother's Wasserman was also three-plus.

If I felt a little rusty in my laboratory technique, I would advise getting a technician. If I did not do this, I would line up with some convenient laboratory or the technician of some other fellow, where it would be possible to get your reports the same day they are made. Ten or twenty miles would be no obstacle to send these reports if we would let the family in each instance do the running, and of course, take the worry of the additional expense involved. Or I could write some good laboratory for instructions, as to the routine of urine, feces and blood and get specific instructions as to how to go about it, or, better still, take a day or two off and go to a laboratory and put my cards on the table and the technician will instruct me in the technique of taking smears and refresh my memory in the use of the microscope. This, I say, is not the best, but better than none. Also reference to text books will familiarize a doctor with the most important diseases requiring laboratory methods to make positive diagnosis.

Too often we make a patient suffer unnecessarily, because we make postive diagnoses from chemical observation only, when a few laboratory tests may reveal something entirely different and positive.

Pyelitis occurs very often in children, more so than one ordinarily thinks, particularly so in girls. And that irregular fever that is not readily, positively diagnosed should have a urine examination. It is surprising how often we will find pyelitis, for this condition is impossible to be diagnosed otherwise positively. Then after diagnosis for pyelitis and treatment, should the patient not improve, if not equipped to do Pyelogram and cystoscopy, send the patient to someone who can.

Again we see members of families who have been told that they have tuberculosis. We, of course, realize that we do not always find the Bug in the Sputum, even when the case is active. But if it is found you have more definite statements to make to the family and true facts in the case, that is of satisfaction to yourself, as to whether or not the bug is being thrown off. With this, along with your clinical evidence, and if possible, X-ray, you will do justice to your patient and yourself. There is too often diagnosis of tuberculosis without applying the laboratory tests and X-ray to verify it to aid in such decision. It is up to the medical profession largely to educate and overcome that prevalent laymen's idea of every case having tuberculosis that coughs or expectorates. It means too much to the patient's welfare, to society and all concerned, not to have proof in each instance where possible in making a diagnosis.

The total merit and benefit of accurate laboratory methods to both patient and doctor are volumnious to take up at this time in detail. The summary of my message and the point I wish to make is, that all too often many of us are neglecting the use of the laboratory as we should in our daily work. We are eager to read the daily paper. I see no reason why we should not be just as eager to get daily and read the laboratory reports of the cases that we have observed each day. Even if we get these the day following. And by doing this as part of our daily work several valuable benefits will be derived as follows:

More accurate diagnosis.
More accurate treatments.
Less chronic disease in our midst.
A marked lowering in our death rate.
A fewer number will drift to the quack.

DISCUSSION OF DR. NORWOOD'S PAPER

Dr. Williams: Any man whose work is in the laboratory should realize that his field should be an aid and co-operation with the general practitioner, that to work with him is essential. He should also realize that when in contact with the referring physician he should efface himself as much as possible. The laboratory technician helps the doctor because he knows that he will be checked up on, so he is more careful in his diagnosis.

Dr. Anderson: I have been trying to get Dr. Norwood broke in to writing papers for quite a while. Now he comes out with a good one. I enjoyed it. It was full of stuff. It is hard to estimate the value of persistent and consistent laboratory work. I recall a case that was put on a rest treatment for T. B. when he was literally loaded with hook worms. When the hook worms were cleared out he got as fat as a pig in a potato patch. One time I examined a patient who had been to Memphis for a general examination, but a blood smear was over looked some way. He had lymphogenous leukemia and died in a few hours after the diagnosis was made. Let us heed what Dr. Norwood has said.

Diagnosis and Treatment of Perforated Gastric and Duodenal Ulcers

BY R. D. KIRK, JR. M. D.
Tupelo, Miss.

I shall not endeavor to differentiate gastric and duodenal ulcers in this discussion as they are so closely related. In my series of cases upon which this paper is presented, twenty-six in number, the duodenal ulcer has largely predominated. Neither do I intend to make any attempt to cover the entire field of pathology, the chronic perforating types, etc. I shall try to give you, to refresh your memories again, the symptomatology, clinical signs, and treatment of this dramatic condition.

I believe there is scarcely another abdominal catastrophe that calls for more prompt treatment by the attending physician and surgeon, or another in which the patient will be as insistent that something be done quickly, as in a perforated gastric or duodenal ulcer. You see them in agonizing pain in spite of repeated injections of morphine. They attempt to hurry you in the examination but try to prevent you from palpating the abdomen ever so gently. The most characteristic feature of this pain is the sudden onset, like a bolt from the blue unheralded. Perhaps this is even the first as occured in one of my series.

As a general rule a history of heart burn, chronic indigestion, or occasional pains in the upper abdomen can be elicited. These people are usually in such agony that no previous events can be made to seem important to them. In fact they want to answer just as few questions as possible. After the operation and during the convalescence, if there is one, they often recall for you a very definite history of dyspepsia. Someone has said, some of these patients have had slight indigestion so long they have adopted it as part of their daily lives and cease to comment upon it. Good authorities claim all cases will give a definite history of ulcer if care is taken to bring it out. Others such as the late Dr. Deaver claim that there is a small percent which remain "silent" before perforation.

When a patient presents terrific agonizing pain of sudden onset, located in the epigastrium, with an unwielding rigidity, often in a flat abdomen, costal breathing, grunting with each respiration, anxious expression, set in an immovable frog-like posture, and in a cold sweat, the picture is that of a perforated ulcer. They are in extreme shock, provided we use the term shock to describe his appearance and not his true state of condition as regards the circulation. The pulse is usually very good when seen early. Perhaps not over ninety and of good volume. Some have perhaps made the mistake of waiting for an accelerated pulse which only comes after the inevitable peritonitis has taken a strong hold. To wait for all the cardinal signs of shock is neglect and courting disaster.

There is one observation I have made on all the cases I have seen early after the perforation, which I would like to mention for what it may be worth. Many authors and the men I have been associated with have spoken of the short costal breating in these cases but none that I have been able to find have mentioned a symptom which has invariably been present in all my early cases, those seen in a few hrs. after perforation, and that is, a very definite respiratory grunt. This grunt is much more marked than that heard in pneumonia. Perhaps this is due to pain as the diaphragm encroaches upon the inflamed peritoneum and upper abdominal contents thus forcing the acid contents of the stomach out into the abdomen, or is it a reflex phenomenon thru the phrenic, sympathetic, or what not?

Nausea and vomiting in my series has been very variable, depending upon several factors, such as the size of the perforation, advancement of peritonitis, previous intake of food etc.

In the diagnosis of this condition, it should not be the air of the attendant to try and make a refined finished diagnosis neither should he employ "watchful waiting". It is obvious that an abdominal catastrophe has occured whether it be a perforation or something just as grave. Quickness of action is the essence of good judgment in an emergency of this character, and in the presence of the clinical picture just described, neither the doctor nor surgeon can be held blameless who will delay to make a nice diagnosis before operating. As some have said, "If err we must, as sometimes we may, let us be sure to err on the safe side." When in doubt, operate.

Just a few words as to the differential diagnosis.

Perhaps the hardest differential diagnosis to make would be an acute pancreatitis. In this the pain is terrific and more localized in the epigastrium. This however, occurs usually in well nourished rather fat individuals, who will perhaps give a history of gall bladder disease. The pain is more localized in the epigastrium where a mass can usually be felt. Pulse is bad from the start corresponding to the looks of the patient which as I related before is directly opposite that of perforated ulcer. A peculiar cyanosis, first described by Halstead, appearing upon the face and abdomen, is often seen in pancreatitis.

In acute thoracic diseases with a diaphragmatic pleurisy, often the pain is severe and referred to the abdomen but here the temperature is higher and respirations faster. The ratio of temperature, pulse, and respirations are different. With the other chest signs as friction rubs if obtainable, etc. are also of help.

Other conditions in the abdomen that one must think of are volvulus, acute perforation of gall bladder mesenteric thrombosis, and acute appendicitis. These I will only mention as time will not permit of full discussion of each one.

In the treatment of these conditions as I have mentioned before, the thing of prime importance is early operation. Having decided to operate, then comes the operation itself. We must here realize that we are dealing with a patient that is usually dehydrated, with a disturbed ratio of blood chlorides. Means must be arranged to correct this if possible as soon as feasible. Opiates should not be used sparingly.

As to the technique of operation there are several procedures in practice. I prefer a high right para-median incision of ample length. This gives ample room for a gastric and duodenal exposure.

There are several methods of dealing with the condition in the abdomen, each designed to meet certain conditions; namely,

(1) Simple Suture of perforation.
(2) Suture of perforation together with posterior gastro-enterostomy.
(3) Pyloroplasty or partial gastrectomy with anastamosis.

I must confess my attitude toward conservatism and also I would like to say that I attribute part of this to my lack of experience with the more complicated gastric operations. However, in face of the results I have had in my cases to date, I think the plan I have used, simple suture of perforation, has been sufficient. I have been fortunate I suppose not to encounter any cases in which as far as I was able to determine, there was sufficient obstruction in the duodenum to warrant further operative procedure. I have had some cases that I am sure a gastroenterostomy could have been performed safely, but I have not seen that it was indicated. In fact, I have always felt that it would be safer to operate later again in those cases that called for it under more favorable conditions. Also, I have felt that the mortality rate could not help be higher when additional work was done. Often the field is sterile in spite of all the soiled appearance, but it is impossible to know just when this is the case and to do a gastroenterostomy in the presence of infection, opening up the lesser cavity, means a spreading presence of infection, opening up the lesser cavity, means a spreading peritonitis. I do not believe there is any advantage, from a drainage standpoint, of a gastroenterostomy. Neither do I fear enough the danger of leakage from a simple closure, to do a gastroenterostomy. I believe the one main indication, which I have not had or recognized, for additional procedures other than simple closure, is a stenosis at the pylorus after perforation has been closed. I believe a Finney pyloroplasty is the operation of choice in selected cases. The perforation may be closed either by purse string or mattress suture, the choice of each to be determined by amount of enduration in tissues, and reinforced by over flap of adjacent omentum. A report from the New York Hospital states that in 99 cases that had simple closure alone at the primary operation only 10 required secondary operation of gastroenterostomy. Certainly these remaining ten could be done under more favorable conditions then than at the time of perforation.

The question of drainage will always arise. It is certainly a temptation to drain from all possible sources when we see the abdomen so contaminated. I think the judgment of the operator in each particular case should decide this. The time that has elapsed since the perforation should be a deciding factor. The more cases I have, the more I am convinced that drainage of these cases is rarely indicated. Those I have drained, and they are in the majority, I have seen but little benefit except in two cases in which I got a purulent discharge for several days. If it is to be used it should be removed early. A drain placed in the supra-pubic region should be of benefit in late

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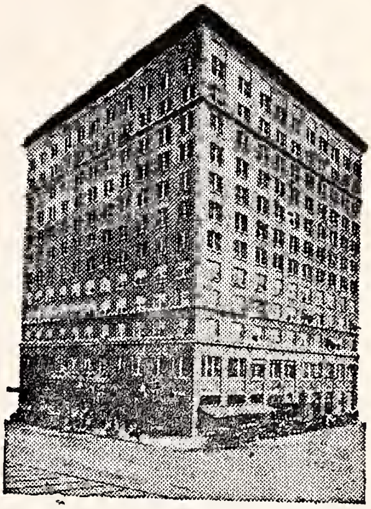

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cases. I believe it is folly to think we can drain the entire abdomen. Of this series 35 percent were closed without drainage.

The post-operative care should consist of nothing by mouth for several days, to be governed by the individual case, morphine every four hrs., normal saline by clisis, and often hypertonic salt solution if peritonitis is present. Glucose by infusion and clisis as indicated I have discontinued the Murphy Drip and rectal instillations as I have deemed that method of treatment as uncertain and as an annoyance to the patient, also because it excites peristalsis which should be limited if possible. In those cases with peritonitis, enemas should rarely if ever be given until the patient is well on the road to convalescence.

If the patient is fortunate to recover, he should be kept on a strict diet and medicinal alkalies until free of symptoms and then some.

Of the twenty-six patients I have had, six died, giving a mortality rate of 23 plus percent. The average time elapsing after perforation before operation was 23 hours. The shortest was 2 hours and the longest was 76 hours in a case in which the gall bladder blocked the perforation. These figures mean practically nothing and are misleading as some in this series had gone long hours before operation thus pulling the average time up. However in this series there were only three cases in which the time elapsing was under twelve hours. Some surgeons generally regard the dead line around the fifteenth hour unless some plugging up has taken place by some abdominal viscera.

Discussion of Dr. Kirk's paper "Diagnosis and Treatment of Perforated Gastric and Duodenal Ulcers."

Dr. Sutherland: This paper should be discussed by a person who is thoroughly familiar with it. There are two cases I should like to mention which were brought in suffering excruciating pain. After a few hours were pulseless and I did not operate. Both died. I suggest that Dr. Sanders and Dr. Crisler take my time; both men are more experienced than I.

Dr. Sanders: I want to say that Dr. Kirk's experience has been unique and certainly worthy of comment. I met a friend this morning who had just returned from England, where perforated ulcers seem far more prevalent than in this country. Why? All the men report their cases. If we in America would report our cases there would be just as many as in England —What shall we do with ulcers? I think one thing is to handle the cases surgically rather than medically. Many ulcers go on for a long time without perforating, and I don't mean that ulcers ought not to be treated medically. Nor is surgical treatment perfect, but there are not so many catastrophes as there are in the

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medically managed ulcers. I was looking up my cases before coming down and found that in the last five years I have had 76 cases, 33 of whom were men, with an average age of 34 years. Usually the patient will lie perfectly still—this is contra-distinctice to the kidney stone and gall colic patient—and he wants to remain still. The muscles are board-like, rigid; nature's protection. The perforated ulcer problem is a dramatic catastrophe that demands immediate action. And the main points are; to sand-bag the hole, stop the leak and save a life.

Dr. Byran: Is death inevitable when the ulcer perforates and no surgery is employed?

Dr. Sanders: When there is an immediate pouring out of the gastric contents and there is no protection, there is no hope. But when nature has thrown a little omentum protection around the perforation, there might be a chance for recovery.

Dr. Crisler: I was very much impressed by Dr. Kirk's paper, particularly the part about taking the patient's history. One always finds that one cannot get the patient interested in his history. We have to take only the present history and make the diagnosis from a careful examination in the field of the abdomen. However, I don't feel quite as Dr. Sanders and others about surgery.

Among the doctors over the country a pretty high percent of them have ulcer, and they usually carry a little soda-mint tablet along in their pockets to take, so they must prefer that the patient be given medical treatment in most cases, except acute ulcers. I think that after we have operated upon a patient we should turn him back to the medical man for treatment and diet, for he is by no means well.

Dr. Kirk: I thank these doctors who have offered these fine suggestions. I would suggest to Dr. Sutherland that his two cases were probably mesenteric thrombosis. That is my guess, for the pulse and patient went bad too quickly. I might add that if the whole responsibility were placed upon the medical man, then we should have fewer perforations.

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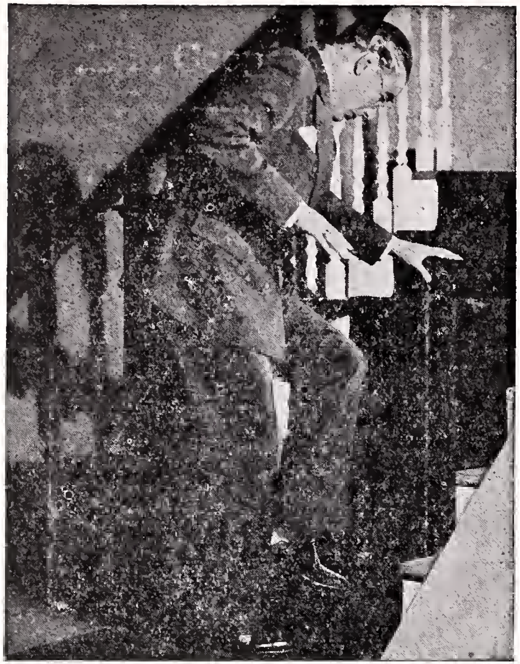

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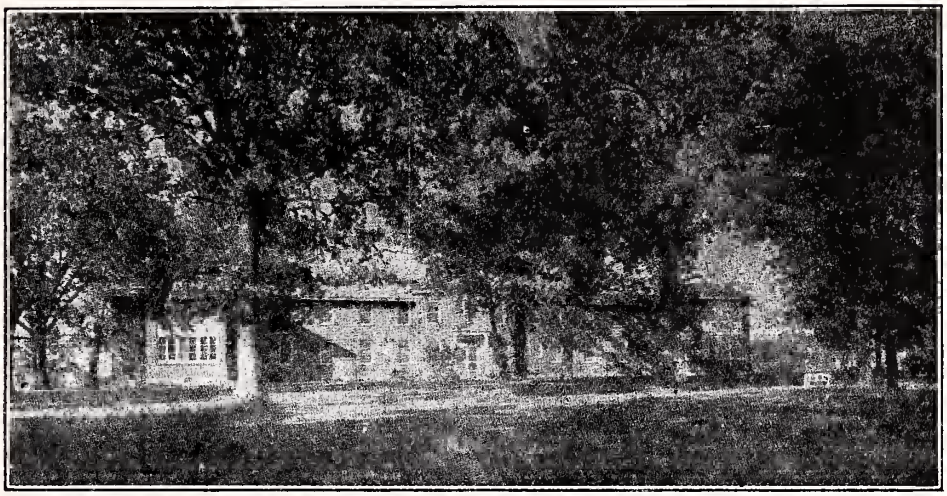

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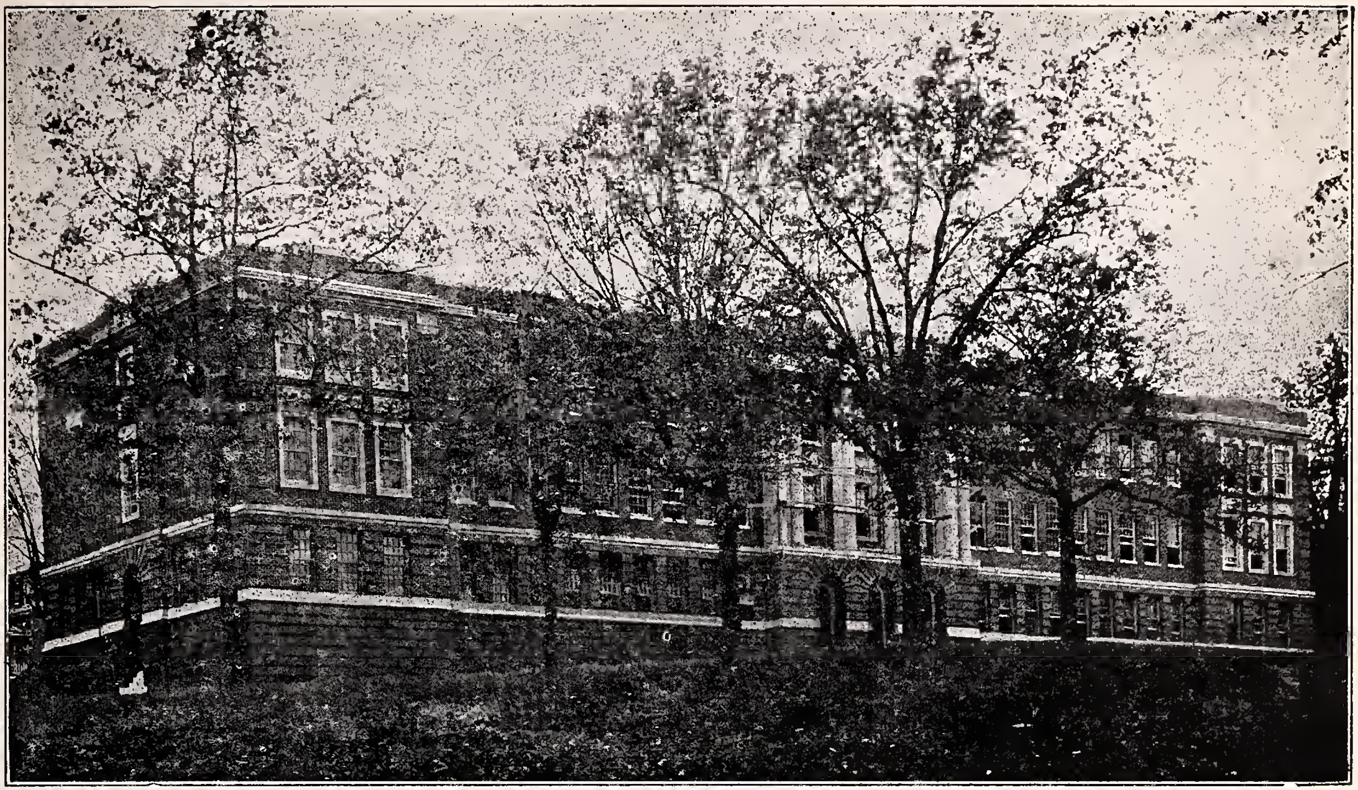

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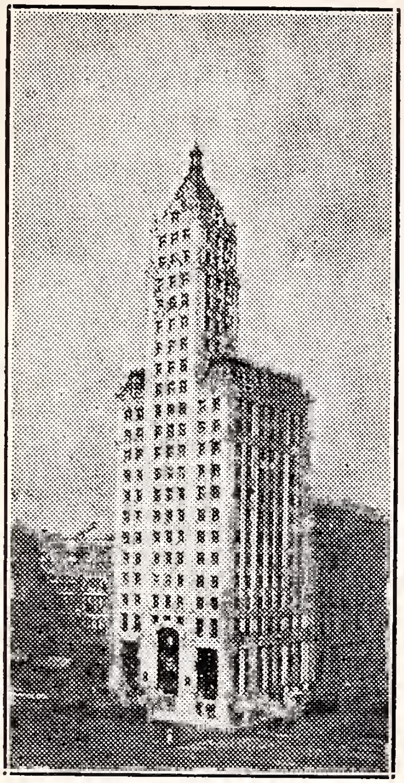

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Motherhood

God made the streams that gurgle down the purple mountain side—
He made the gorgeous coloring with which the sunset's dyed.
He made the hills and covered them with glory; and He made
The sparkle on the dewdrop and the flecks of light and shade;
Then knowing all earth needed was a climax for her charms;
He made a little woman with a baby in her arms.
He made the arching rainbow that is thrown across the sky,
He made the blessed flowers that nod and smile as we pass by
He made the gladsome beauty as she bows with queenly grace,
But sweetest of them all—He made the lovelight in the face
That bends above a baby, warding off the world's alarms—
That dainty little woman with a baby in her arms.
A soft pink wrap embellished with a vine in silken thread
A fiimly, snow-white cap upon a downy little head—
A dress 'twould make the winter drift look dusty by its side—
Two cheeks with pure rose petal tint, two blue eyes wonder wide—
And blending o'er—the mother face imbued with heaven's own charms
God bless the little woman with a baby in her arms.

—Author Unknown

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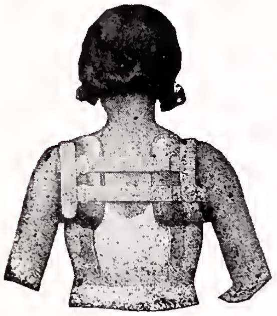

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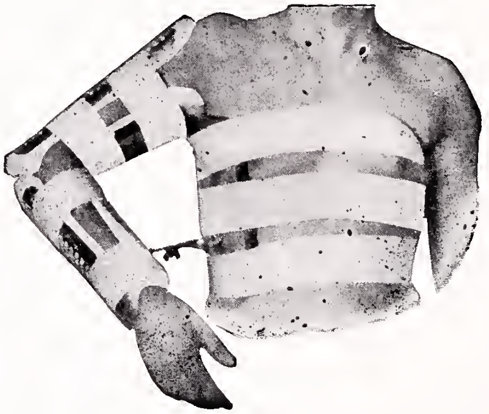

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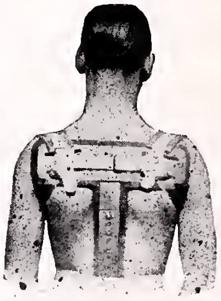

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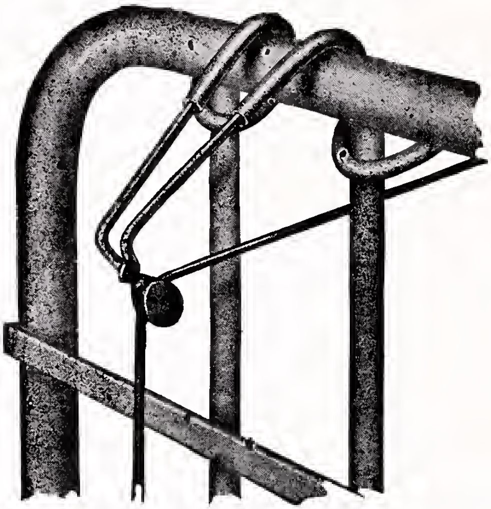

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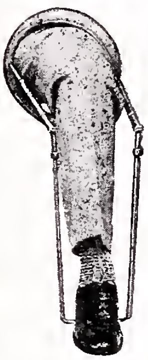

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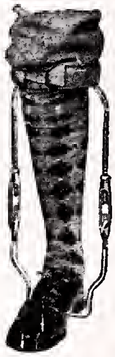

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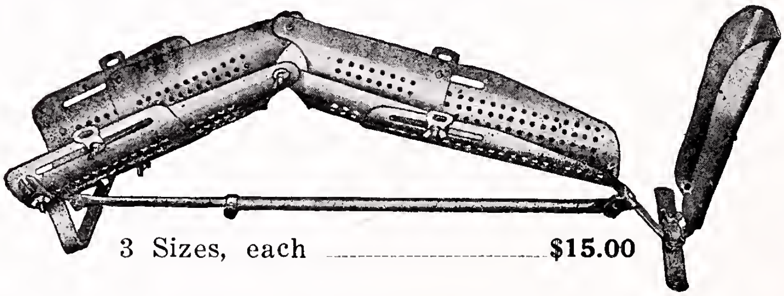

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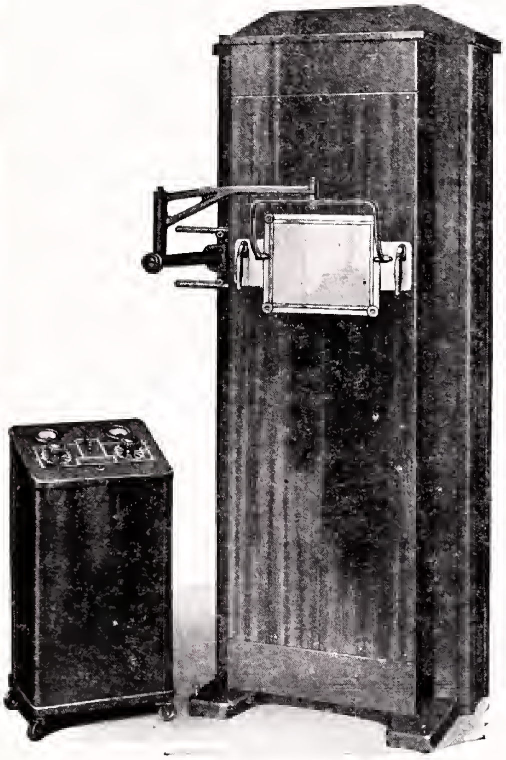

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OFFICIAL ORGAN OF THE NORTHEAST
MISSISSIPPI 13-COUNTY MEDICAL SOCIETY
—AND—
NORTH MISSISSIPPI 6-COUNTY MEDICAL
SOCIETY

W. H. ANDERSON, M. D., Editor and Manager

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The man who wins is the man who has the driving power to keep on keeping on.

The people are rapidly demanding co-operative medicine at the hands of the profession.

Any man can learn surgical technic, but surgical judgment is reserved for the chosen few.

We appreciate the splendid paper on the treatment of burns by Dr. W. E. Akin of Vicksburg.

It is just as important to know your individual patient as it is to know the exciting cause of the disease making the attack.

We hope you take advantage of our special offer of one dollar for one year for The Mississippi Doctor. Let us visit you.

Saving the life of the patient should be the chief aim of any practitioner at any time, any where and under any circumstances.

The most important business of the medical profession at this time is the artful application of the known and proven medical truths.

You will read with interest and profit the paper on Chorea by Dr. F. M. Acree of Greeneville. We thank him for this splendid contribution.

You will read with interest the news department at Ole Miss Medical Department by W. D. Beacham. He is a fine reporter and we are grateful to him.

The Southern Surgeon has made is appearance, Volume 1, Number 1, April, 1932. We want to express our appreciation to the editors for a copy of this journal. Its papers are of the highest type. The journal is well edited. It has large and clear print. It is readable. You may think that you are already taking more Journals than you can read. May be you are taking more than you do read, but The Southern Surgeon is one that you will not likely want to do without. The name impresses you. It is the official organ of The Southeastern Surgical Congress. It is published quarterly and the price is very reasonable, three dollars per annum. When you read this journal you will have a feeling that it is coming to you as a personal friend. We predict that it is going to be a very popular journal. It will bring you technical knowledge and teach you how to use it. It will be a big factor in developing the Southern Surgeon who has always had originality and who is resourceful. It has an open, free, and easy touch in expression and a brotherly interest speaking out between the lines. Elsewhere you will see a list of the editors.

If you have an interesting case write it up in in good style, briefly and to the point and send it to us for publication. We will thank you for this bit of service.

We are delighted to have among our brand new cash subscribers in advance, Drs. A. F. Cooper, Memphis; Lowrey Rush, Meridian; George Kirby Sims, Laurel; F. M. Acree, L. C. Davis, C. P. Thompson, and Gamble Bros. & Montgomery, Greenville. The Mississippi Doctor will be mighty proud to visit them each month. We thank these good and progressive men.

Our state association acted wisely at its last meeting in deciding to meet again next year in Jackson, the state capital. Jackson is a fine convention town. Every one loves to go to Jackson. Here is where we have the best attendance and where we have the best interest in the program. It would not be a bad idea to make it the permanent place of meeting just as we have done with the Mid-South at Memphis.

Our June meeting will be held in Amory. Make ready to go. Go down and get professional enlightment and at the same time catch the spirit of the gas field and be imbued with the optomistic spirit. Amory is a fine town filled with a fine bunch of doctors. It is the home of Dr. G. S. Bryan who is full to overflowing with Southern hospitality. He will charge you with cheer and good will. Be on your way to Amory.

Specialties and specialists are multiplied in the medical profession, but even so we still have one open field, that of Geriatrics. The aged deserve special attention as much as do the children We have been too prone to shake our heads and blame it on age when we are called to see a person past sixty five. In the economical field the man past sixty has been looked upon as a step child. He has not had what was coming to him. It has been unjust and unfair to him and it has been very bad for the country at large. The medical profession should be the last to pass up the aged as worthless. The ills of the aged deserve special study. If a man keeps himself physically and mentally fit he is worth more to society every day that he lives though he live to be a century old. It is a shame for us to continue to waste the wisdom and the knowledge of the man past 65. We are losing enough in him to enrich our nation. Our treatment of the men and women past sixty five is in keeping with a man who will build a barn and not cover it, keep a flock of sheep and never shear them, to planting a crop and stopping cultivation in the middle. We need the knowledge and the wisdom of the man past sixty five as stepping stones to gather truths and wiser judgments. Potentially the aged have the wealth, the knowledge, the wisdom, the culture, the refinement, and the ideals to enrich our nation and make it happier. As a medical profession let us do our part. Let us conserve the health of the aged and increase our wealth and that of the nation. They deserve it and they are appreciative. Let us have some specialists in the field of geriatrics.

We are glad to have a splendid paper from the pen of George Kirby Sims of Laurel who has not been in our state very long. It is a splendid dissertation on the differential diagnosis of appendicitis. Appendicitis like the poor we have with us always. When we are called to see a patient with an abdominal pain we should always prove that it is not appendicitis. The average case of acute appendicitis should be diagnosed and operated upon within six hours of the onset if the laity and the physician know the five symptoms in the order in which they appear. We are losing too many patients from appendicitis, may be because we are still talking about appendicitis instead of operating. Know appendicitis in all of its ramifications and you will know a mighty lot on the inside of the human abdomen. We thank Dr. Sims for his splendid paper.

The small hospitals received some aid for the indigent poor. The amount is very meager. It will help some. It was probably about as good as could be done with the system we are trying to operate under. If we keep the five state charity hospitals and maintain them of course there can not be much left for the small hospitals over the state. The state charity hospital system we have is expensive and it does not reach the people. We have outlived its day. Medical service must be brought to the rank and file in the country and the small town. The small town is the place where the medical profession and the people can meet and make their exchange profitably. Mississippi should hav vision enough to put the charity funds over the state where every person may be benefitted. This was the time propitious to do this while the cry of economy was on every lip. Of the eight state owned charity hospitals in the United States, Mississippi is trying to operate five of them. These five hospitals are reached, economically and efficiently by about one fifth of the population in our state, yet they are given four times the aid of all the small ones over the state. Some representatives cried "pork barrel" legislation in their fight against the community hosuital. If it were it is better to have pork in the barrel for every one rather than furnishing a spoils system for a few politicians. The system the medical association asked the legislature to put in vogue would have removed this charity service entirely out of politics and would have multiplied the service ten times in the state as a whole. It is pitiable that we can not make more progress in our method of distributing funds over the state to our needy people.

Book Review

Another of the publications of the White House Conference on Child Health and Protection came to us. It is "Obstetric Education," compiled from the work and discussions of the Committee on Prenatal and Maternal Care, and is one of the best of the series. A discussion is made of graduate work being offered nowadays by most universities and medical schools for higher training in obstetrics and maternity care. This is supplemented by detailed reports of undergraduate opportunities provided in clinics, hospitals and general practice. A second division of the book gives significant findings in the training of nurses and nursing attendants, recommendations and reports from various parts of the country. And a third deals with the work of midwives and the challenge to the medical profession for more efficient service from the laity and from social workers.

The entire book seeks to enlighten the profession to the extent that it will become more awake to the responsibilities incumbent upon it in reducing the alarming maternal and infant mortality rate. This may be done more through educating the public than more expensive clinical equipment. The fact that the medical profession does not take the initiative in promoting maternal welfare work is deplored, and suggestions are made for effective methods of carrying out a constant educational movement. Published by the Century Co., New York City. Price $2.00.

Osteomyelitis

Dr. W. H. Anderson, Editor
Booneville, Miss.

My Dear Dr. Anderson:

Your request that I send you a written outline of my discussion of "Osteomyelitis" at the Booneville meeting, has been received. It will be difficult, if not impossible, for me to do this, since I do not remember exactly how I approached the subject.

However, I do remember that I stated in the outset that I had not written a paper nor had I prepared an academic lecture on the subject—that I would not try to bring any thing new. Rather that I simply wanted to remind my hearers, in a conversational way of the things that they all knew as well as I did. (Infact, so far as I know, there is nothing new to be said on the subject unless the use of sterile maggots in the treatment of chronic cases be considered new). I tried to emphasize the fact that early recognition of the condition and prompt and proper treatment is all important and that the responsibility in this regard rests entirely on the general practitioner. I insisted that there should be little, if any, trouble in this respect if the family doctor would keep in his mind the things that all properly taught and trained men should know.

Among these things I would mention that osteomyelitis is not infrequently seen and that it is a very grave condition—grave because of the great amount of suffering that it entails—grave because of the high mortality rate that it has and exceedingly grave because of the great amount of deformity and permanent disability that so frequently follows in its wake in the cases who do not die. I insisted that it was easy to recognize because it simulated nothing but rheumatism and that it was really inexcusable to confuse it with this trouble.

Osteomyelitis is a destructive process involving bone and its marrow and periosteum. It may involve any bone, but it most usually attacks one (or more) of the long bones. It never attacks, primarily, a joint but usually begins near a joint—not far from one of the epiphereal lines. After a time it may break thru this line and then it involves the joint. It is sudden in its onset and is most dramatic thruout its course. Dramatic in its excruciating pain—in its high death rate and in its great deforming and disabling sequences. But the most dramatic and regretable feature is the fact that all these dramatic and disastrous consequences, are chargeable, in most cases, to failure or neglect on the part of the family physician. (Of course where the family does not, immediately, call the family doctor, the blame rests upon them). Let me report a single case that will illustrate both the gravity and the drama of these cases:

A young man in his late teens—an almost perfect physical specimen—a leader in high school athletics—in the pink of health and condition—in great exuberance of spirits—was taking a Sunday morning walk and during this walk he met an elderly but most friendly lady. They joked a bit and then engaged in a little sham battle. While so engaged a terrific pain struck the upper part of his thigh. He thought he had sprained his hip. He limped away and after going some fifty yards sat down. He was carried to his home. Soon a severe chill came on, followed by a sudden and high rise of fever. His doctor was summoned. He grew worse rapidly. On Tuesday he was carried to a hospital in a town large enough to support two or three hospitals. I do not know the diagnosis made nor treatment suggested. But late Thursday afternoon he was brought to the Gilmore Sanitarium in Amory and I was called to see him. I found that he was suffering from acute osteomyelitis. He was delirious and moribund. He died two hours after reaching the hospital. Had his condition been recognized immediately and an incision made down to region of troconta and a few gimlet holes made into the centre of the bone, perhaps this young man's life might have been saved. You notice that I say "might have been saved." It must not be forgotten that the severity and gravity of these cases as well as the outcome, depend largely upon the nature of the causative factor in the individual case. This last statement brings me to consider the etiology of the condition under discussion. Any infectious organism that may gain entrance into the blood stream may cause it. I will mention these organisms in the order of frequency, as I think: Staf.; Strep.; Tub. bac.; Typho. bac.; Pneumo. and G. C.

As stated when I presented this subject at Booneville, my only purpose was to try to arouse the diagnostic conscience of our membership and to emphasize the great importance of immediate treatment which is purely and wholly surgical, if seen early. Treatment of chronic cases, which means neglected cases, is another and different question entirely.

Any and all the finer and scientific points applying to this subject may be found in any standard system of medicine or surgery.

Yours truly,
G. S. Bryan.

We thank Dr. Bryan for epitomizing his discourse on this important subject. He has put us on guard. It will be a great help. Ed.

The Treatment of Extensive Burns with Special Feference to the Use of Tannic Acid

BY W. E. AKIN, M.D.
Vicksburg Clinic
Vicksburg, Miss.

CASE REPORT

All burns regardless of the degree that involves more than one-third of the body surface area should be considered as serious and only a guarded prognosis should be offered as to the ultimate outcome of the case.

The treatment resolves itself into the following elements:

1. To relieve pain.
2. To combat shock.
3. Maintain body temperature.
4. To counteract exhaustion.
5. To prevent dehydration.
6. To protect the denuded areas.
7. To prevent and treat the severe toxemia that is characteristic of burns.
8. The prevention of contractures.
9. The replacement of tissue by grafting.

The last mentioned element lies strictly within the realm of surgery and will not be given consideration in this paper.

The patient as well as the burn must be treated and the management of each case individualized. Constant and intelligent nursing is of paramount importance. In the case report offered at the conclusion of this paper, I consider the recovery of the patient due more to the nursing care than to any other factor in the management of the case.

Treatment consists in the use of systemic and local measures. Shock is treated along the usual conventional lines. The body heat should be carefully maintained by the use of a heat cradle; the heat can be regulated by size and number of lights used. Fluids should be forced orally if possible, if not the subcutaneous and intravenous routes should be resorted to. Small daily blood transfusions are of great benefit in combating toxemia. The urninary output must be carefully watched and a fluid balance maintained.

There is convincing evidence that the extreme toxemia so common in extensive burns is due to a toxic principle that is formed from the devitalized burned tissue. Reiss produced toxemia in animals by injecting a substance derived from the urine of burned patients. The exact chemistry of the isolated toxin is as yet not fully understood. The principle is water soluble and is quickly absorbed into the circulation. Reiss infers that aqueous antiseptic solutions should not be applied early unless they possess the power of precipitation of the toxin, because the toxic principle is water soluble.

In 1925 Davidson introduced tannic acid in the treatment of burns. The original method as introduced by him consisted in covering the burned area with a gauze dressing saturated with 2.5 per cent tannic acid solution that had been freshly prepared. The solution never to be used after it is 48 hours old. The gauze was kept moist with the solution for 24 hours or more until the burned tissue was thoroughly tanned. A heat canopy was kept in place over the patient.

In 1926 Beck and Powers offered a modification to Davidson's method. It consisted in using tannic acid spray. The areas to be sprayed every half hour until the surface becomes deep brown or black in color. No compresses were used and the coated area constantly exposed to dry heat. Blebs were opened as soon as formed and the epidermis removed wherever it had separated and the raw area immediately sprayed with tannic acid. It was observed that the area could be thoroughly coated over in 12 or 16 hours.

The above men definitely proved that burned patients, treated with tannic acid suffered less from toxemia than those treated by other methods. It is the concensus of opinion that the lessening of the toxemia be attributed to the precipitation of the toxic material of the burned tissue thus rendering it less soluble. If the burn is superficial, epithelization will proceed under the black escar. The crust usually shows evidence of separation between the 10th and 15th day, thus leaving a clean granulating area. The coagulum should not be loosened or taken off except as it peels off itself, unless there is evidence of pus formation under the crust, in which event the entire escar should be removed with sterile scissors and antiseptic solutions plus dry heat continuously applied.

Beckman has recently compared the end results in a series of 114 cases treated with tannic acid, against 320 cases treated by other methods and reports a reduction in mortality from 28 per cent to 15 per cent and mortality from toxemia alone by two-thirds. Wilson, in a series of 50 cases shows a mortality of 8 per cent.

SUMMARY

Tannic acid treatment of burns marks a real advance in burn therapy. It has received the endorsement of many Clinicians because it diminishes pain, decreases toxic reactions, prevents fluid depletion, promotes smooth granulation and reduces mortality and disability periods.

CASE REPORT

D. M., white male, age 29.

Family history: Negative except for one brother who died of cardiac disease and one sister who died of some complication following surgery, the nature is not known.

Personal History: Patient is a painter by occupation. Has not worked for some time due to depressed conditions Patient is married. Wife and one child living and well.

Past History: Patient gives a history of having sustained a fracture of the right elbow during childhood. No deformity and no further trouble since reduction of the fracture. Usual childhood diseases. Typhoid fever and malarial fever in 1912. In 1924 had double pneumonia.

Cardio-Respiratory: Not remarkable except for double pneumonia in 1924.

Gastro-Intestinal: Negative.

Genito-urinary: Negative.

C. C.: Burns due to scalding water.

Present Illness: Onset thirty minutes before admission. Patient states that he was at one of the local lumber mills for the purpose of purchasing lumber. He walked in front of a blow out valve just at the time when the engineer was blowing out the boiler. Scalding water, under much pressure was sprayed over the entire body. At the time of injury the pain was intense and for five minutes the patient experienced a chilly sensation over the body and was in a semicomatose condition. He was placed in a car and brought immediately to the hospital. He was able to walk to the doctor's office from the car. He was put to bed. Patient was in acute shock at this time.

TREATMENT AND PROGRESS NOTES

No immediate attempt was made to examine patient on admission. He was undressed and placed in bed. Hot water bottles applied to the body and one-third grain of morphine given in an attempt to react the patient from the severe shock. External heat was then applied and the patient was fairly comfortable. Patient was examined rapidly. Patient found to be a male white adult, well developed and well nourished. An anxious expression on the face. Patient still in acute shock. Temperature 96. Pulse rapid, over 100 in number. Respiration shallow, 20 in number. There were burns practically covering two-thirds of the body. They ranged from first to third degree burns. The burns extended from the nape of the neck involving the entire back to the calves of the leg. The burns extending on the right arm and the lower one-third of the forearm anteriorly and posteriorly. On the left the burns extended down to the hands. Minor burns about the hands. Anteriorly, the burns involved the left chest extending about three inches beyond the midline to the right. Both legs anteriorly were burned down to the knees. Scattered areas of first degree burns on the feet. Right chest and right thigh anteriorly being practically the only parts not involved with the exception of the face. Burns about the buttocks and in the left popiteal space were third degree in nature.

Third degree burns under the left axilla and about the right elbow. On the back, the burns were first and second degrees. Examination was confined to inspection and further examination not made at this time. Patient fully reacted and external heat applied. After one hour the devitalized skin was carefully removed and the burned areas sprayed every 15 minutes with tannic acid solution (3 per cent). Patient had been placed on sterile sheets and a heat canopy placed over the body. Eight ounces of fluid offered to the patient each hour. Nurse instructed that the patient was to be made to drink at least eight ounces of fluid per hour for twenty-four hours. After twelve hours the body was covered by a black escar. As fast as blebs were formed, devitalized skin was peeled away and the area sprayed with tannic acid. Fluids were forced. About 8000cc of fluids per day. Blood transfusions were begun on the third day and continued almost daily. A total of 15 transfusions being given in the first twenty-four days. 350cc of citrated blood being the usual amount given. The patient's progress was rather stormy. On the 10th day there was evidence of pus formation, as exemplified by the extreme toxemia of the patient. The tannic acid was removed as it separated from the edges and S. T. 37 packs were constantly applied. On the 10th day digitalization of the patient was done due to the poor condition of the circulatory system. Dry heat in the form of the electric light placed under the canopy was constantly applied. Position changed as often as necessary so that the areas could be dried. S. T. 37 treatment continued and the general care of the patient was maintained. Average fluid intake for the first twenty-one days was 9000cc. Urinary output averaged 3000cc. Urinalysis showed not over 1-60 of 1 per cent albumin. Sugar content of the urine averaged from .3 per cent to .5 per cent. Blood chemistry remained normal. The patient recovered after forty-seven days of illness.

GENERAL EXAMINATION AFTER RECOVERY

Patient is well developed, but greatly undernourished. Weight 122 pounds. Patient has lost forty pounds during the illness. Walks with a slight limp to the left. Eyes: Pupils are markedly dilated, otherwise negative. Nose and mouth negative. Ears and neck negative.

Examination of the skin: The skin posteriorly over the areas described on first examination have completely healed over. There is a small area under the left axilla, left hip and left popiteal space which have not entirely healed. The chest is negative except for emaciation. Heart negative. Abdomen negative. The extremities are greatly emaciated. Considerable scarring of the right elbow. Some slight retraction. Extension and flexion, however, normal. There is marked scar formation and contraction in the left popiteal space. Extension and flexion being only partial. Several healed boils scattered over the thighs and legs. Reflexes are hyperactive. The patient is highly nervous. There is a fine tremor present. Patient, however, was able to walk out of the Clinic. We advised to return to the Clinic for dressing and check up.

Chorea*

BY F. M. ACREE, B.S., M.D., F.A.C.P.
Greenville, Miss.

Chorea is a Latin word taken from the Greek word meaning dance. It is a convulsive nervous disease, commonly called St. Vitus' Dance, with involuntary and irregular jerking movements; it is attended with irritability and depression, and mental impairment. It occurs especially in early life, affecting girls more frequently than boys, and is often hereditary. It is very varied in its nervous manifestations in that it may affect a single group of muscles as in Chorea Nutans, in which there is a nodding spasm, or chorea with nodding head movements, or Chorea Scriptorium, which is plain writers' cramps, or it may affect the whole body as in Chorea Major (Huntingdons) or Chronic Chorea, an hereditary affection of adults marked by irregular movements, speech disturbances, dementia, and hysteria. Automatic Chorea is characterized by the performance of actions that seem to be intentional but which are really performed independently of the will in response to some impulse or external stimulus; Buttonmakers' Chorea is an occupation neurosis observed in buttonmakers; Chorea Cordis is chorea with great irregularity of the heart action; Chorea Cravidarium is chorea with symptoms similar to the ordinary form, seen in pregnancy; Methodic Chorea, a variety in which the movements take place at regular intervals, rhythmic and persistent; School-made Chorea is caused from overstimulation at school, and Chorea Minor, or Sydenhams, the ordinary chorea with comparatively moderate convulsive movements, are about half of the some two dozen various kinds of Chorea. (1)

The etiology of Chorea is not known. Morse (2) in his Clinical Pediatrics, makes the statement that "Chorea is a functional disease of the nervous system" and "is not due to syphilis" but the very close clinical relationship between acute articular rheumatism, chorea, and endocarditis brings much weight to the various theories that it is bacterial in origin, since much experimental work has tended to show that acute articular rheumatism and endocarditis are very likely bacterial in origin because of the frequency with which local foci of infection, especially in the teeth or tonsils, are present in these conditions. Rosenow (3) in the "Archieves of Neurology and Psychiatry", reports the results of experimental infection of animals with material from foci of infection, or the throats of patients suffering from various diseases of the nervous system, and the specific localizing power of the streptococcus, it would seem, is dependent, in part at least, on the production of a toxin or poison that has specific effects. Hypernea, with marked arrhythmia, and the symptoms characteristic of spasmodic torticollis have been produced with filtrates from naso-pharyngeal washings, filtrates of suspensions of pus from tonsils and filtrates of old cultures of the specific streptococcus in each of these conditions. The fact that the streptococcus, having specific effects and the power to produce a specific poison, has been isolated long after onset, indicates that the late manifestations of encephalitis and allied conditions are not sequels but are due to the activity of the causative organisms or its toxin. Charles A. McKendree (4), writing in Blumers Bedside Diagnosis, says that "Endocarditis has been suggested as a causative factor, through embolism. We look upon Sydenhams Chorea as a disease having organic pathology in the brain, and yet it is difficult to explain certain cases which have their origin apparently in psychic trauma—such as fright, grief, anxiety, pressure activity at school, etc. It is possible that emotional disturbances bring to the front choreic signs that have previously been masked."

No more is known about the pathology of Chorea than is known about the etiology. Since complete clinical recovery occurs it is logical to suppose that the lesion, if there is one, is not serious or extensive. The symptomatology points definitely to the motor tract of the central nervous system, and the consensus of opinion is that it is a vascular manifestation in either the cortex or basal ganglia.

The symptomatology is as varied as is the types of Chorea. Most commonly the child is "a nervous child—has always been," to quote its mother. It is noticed that she has become very cross and irritable and cannot be still a minute; she may complain of vague pains, headache and digestive disturbances for several days before the appearance of the peculiar twitchings that are characteristic of the disease. The muscles of the hands and fingers, face and tongue are the most often involved, though the leg muscles are also often affected. The movements are irregular and purposeless and of varying intensity. The patient soon becomes unable to hold anything in her hands, or even to keep the hands still, speech is affected and the head may be in almost constant motion. The muscular twitchings usually subside when the patient goes to sleep. In some cases a definite valvular heart disease is evident; there may or may not be fever. There is usually some anemia, and the white count is usually normal in the absence of complications.

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*Read at the regular monthly staff meeting of Kings Daughters Hospital, February 10th, 1931.

Diagnosis. Chorea is not often mistaken for anything else but many other things are mistaken for chorea. A careful history should be taken and habit spasms ruled out by examination. These are under control—for a time at least—of the will. Where there is no symptom other than a muscular weakness without twitching, epedemic encephalitis must be ruled out.

Complications. Morse (5) says that "the only important complication of chorea is endocarditis" and that "endocarditis is always present in fatal cases. In fact there is no disease in which endocarditis is so constantly found at autopsy as chorea." C. G. Kerley (6), in the Journal A. M. A., says, "every patient with chorea is looked on and treated as potentially having heart disease. Parents are told of the danger confronting such children and are told that the child should be under medical supervision until she is 12 or more years of age."

Treatment. In reviewing the literature on chorea, one finds many treatments outlined. For many years arsenic was used probably because of the idea that chorea was caused by syphilis. Kolmer (7) states that "while the arsphenamins may be worthy of trial, it cannot be stated that these compounds possess specific curative properties;" and Morse (8) makes the statement that "there is no specific treatment of chorea" and that he has never found arsenic to be of any especial benefit other than a general tonic effect. H. Byrd (9), of Tampa, Florida, writing in the Archives of Otolaryngology, reports a case of chorea permanently relieved by an injection of 0.5 cc of 95 per cent alcohol with 5 per cent phenol into the nasal ganglion. A French doctor (10) reports a case of chorea in a girlof 12 years, of the acute type, which had failed to improve when treated with rest in bed, a milk diet, and a solution of arsenous acid, improved rapidly when given parathyroid extract, with a complete cure in less than a month. A German doctor (11) reports 2 cases of chorea minor (Sydenhams) in children aged 13, in which he obtained cessation of the worst symptoms in from 24 hours to 3 days, and cure in from 2 to 4 weeks by passive hyperemia. The passive hyperemia is produced by the application of a rubber bandage (garter elastic) to the throat. It should be tight enough to cause redness of the face and, after a certain time, slight oedema. Many vaccines have been elaborated and tried with little success. The removal of foci of infections has not always brought improvment. W. B. Farnum (12), writing in the October 1928 issue of the American Jour. of Medical Science, reports the studies of a large number of tonsillectomized and non-tonsillectomized cases in which it is shown that the incidence of chorea was 0.4 and 0.5 per cent respectively. Rest in bed, plenty of good food, fresh air and sunshine and a correct, quiet environment have seemed to give the best results, up to the record of A. E. Vipond (13), writing in the Archives of Pediatrics, who reports a series of cases of chorea treated by the injection of sterile milk, in addition to the above environmental influences.

Case Report—C. B., a white female, age 9, was first seen on October 26, 1930, at her home. The complaint was "Pain in the neck and fever." She was lying in bed, apparently not acutely ill, though her face was rather flushed and there was a slight cough, which was caused, she said, by a sore throat. The onset of symptoms was 24 hours previous, though they had not been severe enough to keep her out of school. She had had no rigor nor any other pain. Appetite fair, no digestive disturbance, no nausea or vomiting, elimination good. Temperature was 103 F, pulse 100, respiration 18. She was a well developed, and fairly well nourished girl. Eyes normal on the exterior, pupils reacted to light and accommodation. No nasal discharge. The throat was red and congested, tonsils enlarged and apparently infected. Teeth in good shape. The glands of her neck were enlarged and tender on both sides, in the anterior triangle. An occasional scattered rale was heard over the lungs, no areas of percussion dullness noted. Heart was not enlarged, rapid, no murmurs or skipped beats heard. Abdomen flat, no masses or tenderness noted. Genitals not examined. Extermities apparently normal. Skin smooth, warm and dry. She seemed nervous, but no twitchings were noted at this time. She had had the usual childhood diseases, (mumps, pertussis and chicken pox) and had had frequent sore throat, but had seemed to be fairly healthful child otherwise. A diagnosis of acute tonsillitis was made and some salicylates given. She was put to bed, a bland diet given, and fluids were to be given freely. On the morning of the 27th it was noted that she seemed more nervous, tossed her head from side to side and kept her hands in almost constant motion. She was quite quarrelsome. Her temperature was 101 F, pulse 94, respiration 18. The throat condition had markedly improved. She complained of the pain in her neck.

On the morning of the 28th she had the definite muscular twitchings of chorea; she could not grasp objects with her hands nor could she walk, the gait being ataxic. In consultation with Dr. R. E. Wilson, the diagnosis of chorea was confirmed and Elixir Luminal and Arsenic (Fowlers sol) was given. She was given a bland diet, visitors were forbidden, and she was kept in bed in a quiet room. She improved slowly and on Nov. 4th, 9 days after the onset of the fever, it was noted that there was fair co-ordination of her hands and that she could walk a bit with help. The milk injection treatment was started on Nov. 6th; she was given 5 cc intramuscularly every 5 days and showed a rapid improvement from the first, the third and last injection being given on Nov. 14th, at which time she was able to walk as normally as ever, and was found, on a surprise visit, sitting on the bed cutting out paper dolls.

Laboratory: October 28; W. B. C. 10500—Polys 73% Nov. 7 (after first milk injection) W. B. C. 14500 Polys 70%.

October 27—Urine, acid, Sp Gr. 1012, straw color, negative for albumen and sugar. No casts, a few pus cells and fairly many epithelial. No red blood cells found.

It was advised that she be taken out of school and if possible sent to the country for a long visit. She did not go, however, but has continued to improve. During the month of January she developed a recurrent deafness due to stoppage of the eustachian tube and after several dilitations of the tube with only temporary relief, a tonsillectomy was advised by the consulting otolaryngologist, and they were removed under general anesthesia on February 5th last. Her stay in the hospital was uneventful and she has had no further deafness. She continues to improve and is less nervous.

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The Differential Diagnosis of Appendicitis

BY GEORGE KIRBY SIMS, B.Sc., M.D.
Laurel, Miss.

POSITION—Ordinarily, one visualizes the appendix as occupying a position directly posterior to the area designated as McBurney's Point. As a very matter of fact, however, it has been brought to our attention that the organ may occupy practically any place in the abdominal cavity, including the pelvis, or even a hernial sac.

TYPES—There are three particular types of appendices with which we come in contact upon invading the peritoneal cavity. These are usually referred to as the common, or ordinary types of appendices. The most frequent is that of the infantile appendix, a continuation or rather a termination of the caecum. There is an anterior type, lying on the anterior aspect of the caecum. And lastly, one not infrequently finds a posterior or retrocaecal appendix, occupying the position suggested by its name, and giving rise to symptoms entirely different than those of either of the other types mentioned.

ETIOLOGY—The predisposing causes of appendicitis are those which are referable largely to the anatomy of the organ, inasmuch as the imperfect ileocaecal valve permits foreign objects, such as feces, bacteria, etc., to enter its lumen while the muscular peristalsis is entirely too weak to expel the contents. The lumen of the organ may be unusually narrow, making it difficult or almost impossible for the expulsion of these materials which are held under pressure, creating stagnation and favoring bacterial growth because of the excellence of the medium. Of course the appendix is rich in lymphoid follicles which are distinctly susceptible to bacterial invasion and infection. The incidence of appendicitis following acute tonsillitic attacks is well known to us all and bears out the relationship of the idea of autoinfectivitiy. With all these conditions, along with the fact that there is a lowered, local resistance, we have an ideal condition for a fulminating infection.

The usual exciting organisms are the colon bacillus, the streptococcus, the staphylococcus and the pneumococcus; though several other organisms, and especially the amoeba histolytic, may be presented. If B. Coli is the causative factor there will be early pus formation and its odor at operation cannot be mistaken. Its spread to the edges of the abdominal incision should be guarded meticulously because of the early, extensive invasion and destruction which may be brought about through its rapid incubation. The streptococcic organism scarcely creates visible pus and has no odor, but it is highly infective and runs a rapidly virulent course with a tendency to an early rupture which is followed by general peritonitis, usually in death.

SYMPTOMS—An intelligent understanding of the symptoms of appendicitis can be readily interpreted, clinically, if the underlying pathological changes are properly analysed. Pain, though not severe and usually the predominating complaint, manifesting itself initially throughout the abdominal region, is brought about by a reflex emanating from the sympathetic ganglia, coming by way of the spinal nerves as a result of tension upon the peritoneal covering of the appendix and the caecum. The general abdominal distress is also caused by a reflex in which the bowel, through increased peristalsis, has attempted to assist the appendix in expelling its contents. After a few hours the pain, due to intra-appendicular tension, tends to localize at the seat of the diseased organ. Slight, localized tenderness is usually complained of at this time. And due to a further reflex irritation, nausea and vomiting follow; though the latter is neither persistent nor intractable. In a mild case three or four attempts cover the extent of this symptom. An increase in temperature may or may not assert itself; it is generally a late symptom; is due to the absorption of toxins and more frequently than not, follows the nausea and vomiting. Seldom does it attain a higher level than 100 degrees to 101 degrees F. It usually remains near that point when present. A moderate leucocytosis of 15,000 to 18,000 may be seen in uncomplicated cases. In a gangrenous appendix, however, the leucocytosis may be conspicuous on account of its absence and the sign is a valuable one. Due to slight spread of the infection to the omentum and the parietal peritoneum the patient complains of more severe, local pain. And last, but by no means least, definite, localized tenderness and marked rigidity of the right rectus muscle may be elicited. These later symptoms complete the picture of appendicitis, are due to a cumulative, appendicular inflammation with an increasing intra-appendicular tension and a reflex action, causing tension of the rectus muscle in its efforts to protect and immobilize the appendix.

THE DIFFERENTIAL DIAGNOSIS of early appendicitis must, of necessity, depend upon the time the patient is seen subsequent to the onset of the attack. In early cases in which we have no more than diffuse abdominal cramps, no diarrhea, with slight tenderness over McBurney's Point, a little nausea, no leucocytosis and a normal temperature, one must consider the so-called "gastritis," mucous colitis, chronic constipation and early cholecystitis.

Not infrequently the patient or members of the family must attribute the illness to some indiscretion in diet; and it is often a veritable problem to convince them of the actual condition involved. The food poisoning is practically always accompanied by a diarrhea. Vomiting is usually persistent. The pain is diffuse and comes in waves or remissions. The temperature is normal or even subnormal and a history of other members of the family so affected may be elicited.

MUCOUS COLITIS usually pursues a chronic or intermittent course and the pain, which is quite severe and usually higher than McBurney's Point is, in a large majority of the cases, on the left side. Frequently stools containing blood, mucous and mucous shreds may be observed.

The pain of chronic constipation, if present at all, is transient, shifts to different segments of the bowel and is not severe. Absence of localized tenderness in the presence of the above findings should clear up the matter.

Early cholecystitis presents a distressing feature to the internist at times (not because of its seriousness) and is rarely diagnosed, since practically all of its symptoms are referable to the stomach and the large intestine. Generally, however, one can elicit a history of belching, distention in the upper abdomen following meals, with much flatus and slight pain, accompanied by some tenderness in the right hypochondrium. The Graham dye test may be of value though it not infrequently reveals nothing of significance.

Let us now view the patient with a well advanced attack of appendicitis. Here, we have a wholly different picture. We note the severe, localized pain and tenderness over the appendiceal area. Nausea and vomiting may be a distressing feature for a short time. There is a definite leucocytosis. The temperature ranges from 99 to 102 degrees F, or even slightly higher in children. The right rectus muscle shows evidences of rigidity even upon slight pressure. In this instance the differential diagnosis causes one to think of other conditions entirely different than those previously discussed.

PYELITIS in the gravid individual may be confused with appendicitis, but the presence of chills with an oscillating temperature curve, tenderness in the loin or lumbar region, with a tendency to frequent urination, in the absence of tenderness or palpation over McBurney's Point, along with a urine examination, will clear up the diagnosis.

ACUTE SALPINGITIS offers difficulty in differentiation, though the temperature is usually higher, the condition generally bilateral and the pain low down in the pelvic quadrants. Vaginal examination reveals a purulent discharge containing intracellular diplococci; and a tender mass may be palpated digitally in the lateral fornices.

RENAL OR URETERAL COLIC may be easily ruled out of the picture by X-ray or a pyelogram in the absence of fever and a leucocytosis; and more especially where there is a frequent desire to urinate with referred pain radiating to the groin or down the leg.

In lead poisoning the history of occupation, chronic constipation, the lead line along the gums, and especially the blood picture in which there is basic granulation of the erythrocytes along with the absence of localized pain and tenderness in the right lower abdominal quadrant, will suffice to eliminate this possibility.

Failure to elicit the patellar reflex in which there is an accompanying loss of pupillary reaction to light and a positive Wassermann reaction will rule out a tabetic crisis.

In the presence of cholelithiasis the pain manifests itself in the right hypochondrium and is most frequently referred to the angle of the scapula of the same side. There may or not be jaundice and the gall bladder can be palpated in case a stone occludes the cystic duct. Vomiting is more persistent and not infrequently intractable and tenderness is marked over the region of the gallbladder. The graham test and X-ray will be of great value in making the final diagnosis.

PNEUMONIA involving the right lower lobe occasionally gives rise to pain in the right lower abdomen on account of irritation along the course of the lower abdominal nerves. This is especially true in children and should be closely observed where an appendicitis is suspected. Definite physical signs, however, may be elicited over the lungs. The pulse and respirations are increased and the temperature reaches 103 to 105 degress F. It may be noted that abdominal resistance at the site of pain relaxes on inspiration, while both pain and tenderness subside when the patient holds his breath.

Appendicitis may be seen concurrently with typhoid fever, though it is rare. A high, persistent temperature with a slow pulse, a leucopenia and a dry tongue should make one suspicious of this condition. The presence of rose spots with enlargement of the spleen which may be observed after the second week will clear up the difficulty. Finally, a Widal test, if positive, pathognomonic.

An ovarian cyst with a twisted pedicle is known to have obscured the diagnosis of appendicitis, but vaginal examination is of decided value in this instance, since it is possible for one to palpate the offending mass.

Ordinarily, threatened abortion should afford one very little concern in this differentiation provided a history can be obtained. Usually the bearing-down character of the pains and a bloody, vaginal discharge, even in the absence of uterine enlargement, are sufficient.

In the event of a ruptured appendix the picture is again changed, for there is a definite subsidence of pain and the patient may inform the physician that since he no longer has any pain there is no necessity for considering an operation. At this very instance the individual looks acutely ill. His respirations are increased and are more shallow. Slight cyanosis may usually be observed and the temperature goes to a higher level. The pulse is rapid and weak

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and an anxious expression is upon his face. Vomiting becomes more persistent. The blood may show a leucocytosis of 30,000 or more. There is a generalized muscular rigidity of the rectus which may be board-like.

The above picture leads one to suspect the presence of a ruptured peptic ulcer, a ruptured ectopic gestation, a perforated gallbladder, an acute pancreatitis or a thrombosis of the superior mesenteric artery.

In a perforated gastric or duodenal ulcer one usually elicits a history of "indigestion" covering a period of several months or even a few years, though the patient may say that he has been in perfectly good health previous to the present illness. There is a sudden attack of severe, excruciating pain in the epigastrium with fainting and collapse. The pulse, contrary to expectation, is slow and full for the first few hours, after which it becomes weak and rapid. The blood pressure drops and imminent signs of shock are manifest. Vomiting, with or without blood, and subnormal temperature usually follow. Board-like rigidity of the entire abdominal region, in the presence of the above symptoms, is almost pathognomonic of this type of lesion.

A ruptured ectopic pregnancy generally gives rise to a history of the patient having missed a regular menstrual period for a week or more and has noticed that she has been bleeding slightly from the birth canal for three to four weeks. Or, after several years of sterility, she observes that there has been slight vaginal bleeding over a period of two to three weeks; that it stopped for a week or so and again manifested itself as before. Later, this was followed by a sudden attack of pain in one of the lower pelvic quadrants and accompanied by collapse; though in some instances no pain is present. Pallor may be observed. The pulse is rapid. Cold sweat is upon the body. The temperature at first is subnormal; later, somewhat elevated. The patient is prostrate and there is a marked fall in the blood pressure. Rigidity is only slight and as a rule does not manifest itself until several hours after the attack. A digital examination, vaginally, usually reveals a soft, boggy mass attached to the uterus on the side of the rupture and is painful on palpation.

ACUTE PANCREATITIS is usually preceded by a history of paroxysmal attacks of pain of varying intensity with remissions and exacerbations. The muscle rigidity, while generalized, is not nearly so marked as in that of the case of perforated peptic ulcer. The condition is rare and probably more rarely diagnosed, except during laparotomy. The same may be said relative to thrombosis of the superior meseenteric vessels. There is in the latter, however, an absence of any history such as that obtained in peptic ulcers, and the muscle tension is probably not as noticeable as in the presence of these perforations.

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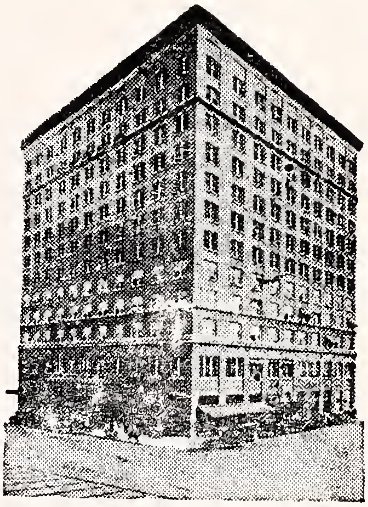

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the gallbladder are preceded by a history of gallbladder disease in which the age of the individual is a suggestive feature. The onset is sudden, thought it more frequently follows in the wake of a severe attack of cholecystitis. Signs of shock manifest themselves early. Vomiting is an outstanding feature; jaundice, also, in many cases. And rigidity, while it may be generalized in extent, is more pronounced in the right hypochondrium.

From the foregoing remarks it might seem that the diagnosis of appendicitis is a formidable precedure, though nothing could be further from the truth. It is only with an intelligent understanding of, and a keen appreciation for, the manifold diagnostic possibilities of the acute, surgical abdomen that our skill can be improved and our patients benefitted.

Relative to the treatment of appendicitis we are prepared to accept the dictum, "In an acute, surgical abdomen either rule out appendicitis or remove the offending organ," I believe that the optimum results will be obtained by this method of procedure.

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Ole Miss News

BY W. D. BEECHAM, JR.
University, Miss.

Dean P. L. Mull will again plead the cause of the University of Mississippi School of Medicine before the council of the American Medical Association on hospitals and medical education at the meeting in New Orleans, May 9, 10, and 11th.

Having been assured by the Board of trustees of the State's educational institutions that every interest of the Medical School will be provided for under the new educational plan to be effected in Mississippi, Dean Mull is optomistic as to the outlook for the next year.

Dr. Culley will make the trip with Dr. Mull.

With the exception of two or three, all of the members of the second-year class have decided upon the medical school which they will attend next year. Dean Mull has been successful in placing the members of this year's class in the following schools: Emory, Louisville, Rush, Tulane, University of Pennsylvania, University of Tennessee, and Vanderbilt. Other institutions including Johns Hopkins and Harvard accepted students but none of those students completing their work here have decided to attend these schools.

Dr. H. C. Ricks, director of the bureau of communicable diseases of the State Board of Health, addressed the members of the Ole Miss medical club on the subject of communicable diseases at the meeting of the club held on the evening of Thursday, April 28th. Doctor Ricks spoke with special reference to smallpox, scarlet fever, typhoid fever, diphtheria, and whooping cough.

The speaker emphasized the fact that an ounce of prevention is worth a pound of cure, and that to suffer from certain diseases is not only a reflection on one's intelligence but a disgrace as well. Upon concluding his instructive and interesting lecture, he declared an open forum and answered the questions of the students.

Dr. J. C. Culley, who had been scheduled as the speaker of the evening, discussed some interesting cases which he has had recently. He then declared that fortune smiled upon us when the representative of the State Board of Halth came our way and introduced Dr. Ricks.

The members of the medical club feel very grateful to Doctor Culley for his address to the State Medical Association. They realize that if there were more men in the medical profession in Mississippi today like Dr. John C. Culley the Ole Miss Medical School would be enjoying the position it so well deserves.

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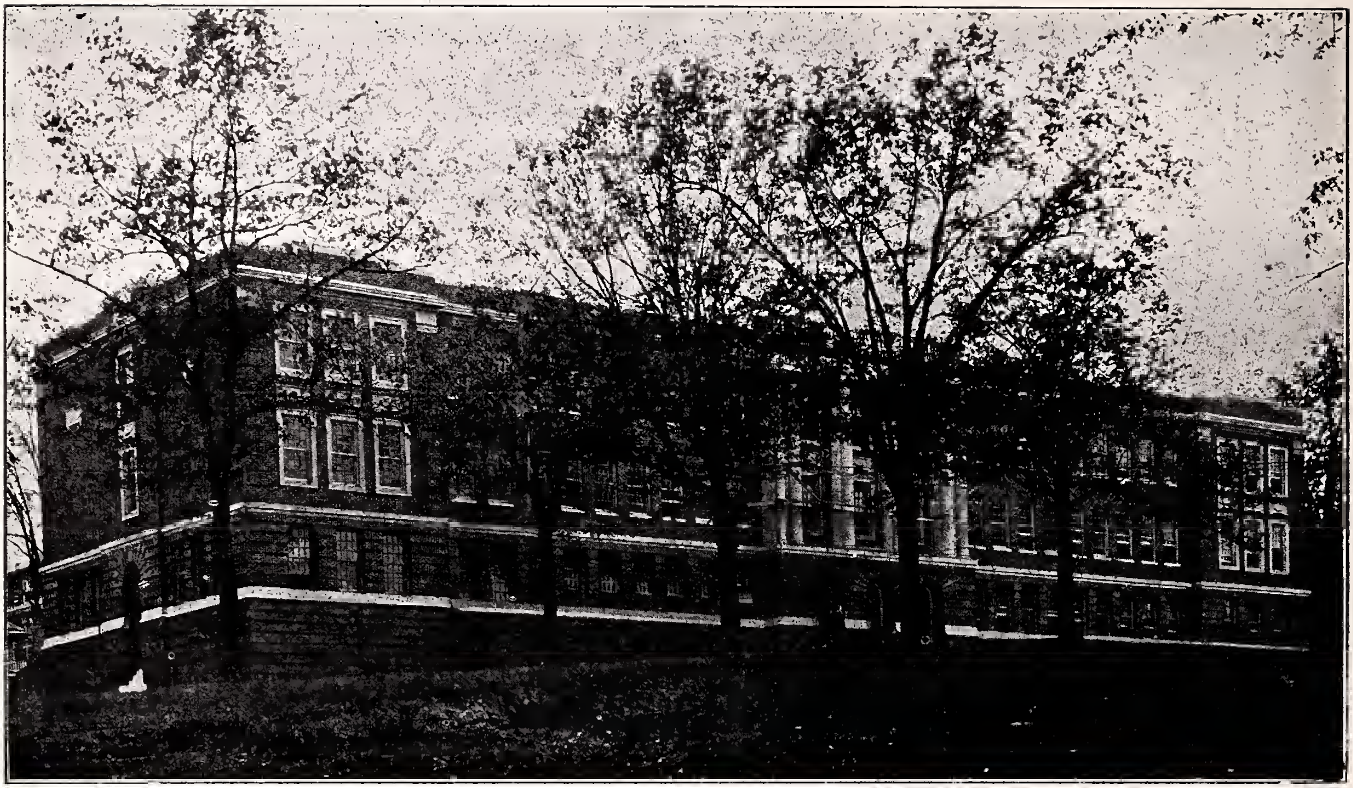

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